

European Commission

Research on Bioethics

# **Beauty and the Doctor**

Moral Issues in Health Care with Regard to Appearance

**Final Report of a European Research Project**

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*Directorate-General  
Science, Research and Development  
EUR PL 963164*

# **Beauty and the Doctor**

Moral Issues in Health Care with Regard to Appearance

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*Report to the European Commission  
Directorate General XII*

*Biomedical and Health Research Programme  
(BIOMED)*

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## **Introduction**

This report presents a summary of the research stimulated by the Concerted Action: Beauty & the Doctor: Moral Issues in Health Care with Regard to Appearance, funded by the European Commission, Directorate General XII, Biomedicine and Health Research Programme (BIOMED)

### ***Objectives***

The project's main objectives were twofold: to characterise people's wishes to medically change their appearance primarily from an ethical and philosophical point of view, and, secondly, to offer an ethical framework for judging these developments and guiding policy decisions in health care at the level of governments as well as the medical profession and the medical professional organisations.

Appearance changing medical interventions have received relatively scant attention in ethics as well as in health care policies. At the same time, the number of appearance changing interventions has risen dramatically in the last decade. This rise partly results from the availability of new medical techniques, but more importantly, it can be ascribed to the ever-increasing significance we attach to appearance. First impressions count more and more in dynamic, modern societies characterised by large social networks built up from brief and varied encounters; a role it did not have in traditional, static societies where people are born, grow up and die within the same confined community where everybody knows everybody else.

In the first part of this report, we give an impression of just how important appearance is, together with a kind of inventory of the diverse problems connected with it. In the second part, we sketch an ethical framework in which suffering plays a central role for both understanding and dealing with the importance of beauty in a medical context. The last part contains our most important conclusions together with a list of practical recommendations.

### ***Participants***

The project ran for three years, from 1<sup>st</sup> March 1998. The coordinating group for this Concerted Action was centred within the Department of Philosophy, Ethics and History of the Medical Sciences at the Erasmus University, Rotterdam, with Inez de Beaufort, professor of medical ethics, as Project Coordinator.

The group was multidisciplinary in nature, comprising of leading experts in diverse fields – applied philosophy, ethics, public health care, sociology, gender studies, theology, medicine, plastic surgery and psychology – from Denmark, U.K., Belgium, Spain, and the Netherlands. In addition to the participants involved, throughout the duration of the project, a number of individuals contributed to the project in a consultative role.

### ***Definitions***

In our report we use the term ‘plastic surgery’ to refer to both reconstructive and cosmetic surgery. In his book *Plastic Surgery in the European Union* (2000), Tan suggests the following definition

Plastic surgery concerns reconstructive and aesthetic surgery. It is a surgical speciality that seeks to improve or restore physical functions or to minimize disfigurement or scarring of the human body resulting from congenital or acquired defects and/or the effects of degeneration or ageing. Its technological instrumentation is surgery based on sound principles of wound healing and tissue repair.

Aesthetic aspects are seen as inherent to plastic surgery. However, plastic surgery is not similar to cosmetic or aesthetic surgery. We therefore use the terms ‘cosmetic’ or ‘aesthetic surgery’ to refer to surgery solely undertaken for reasons of appearance.

### **Statement on Referencing**

In writing this report, we have made use of a number of varied sources. In the first place, we have drawn profusely on the work presented at the four workshops we organised during the course of the project. We make free use of the participants' and the invited speakers' papers without always explicitly mentioning them. We could not have written this report without having access to all the work laid down in these papers. Where we have drawn on published work, either by participants or others, we have given the references in full.

If readers of this report wish to pursue references in more detail, they are invited to correspond directly with the authors who are listed as project participants or consultants.

Where references appear incomplete, the details can be found in Annex I: List of Publications and Conference Addresses.

## Executive Summary

Whatever the reasons to change one's appearance by medical means, and each case is unique, there are some general ethical issues they all have in common. We have discerned four: The first concerns the value and meaning of beauty. What do we mean when we characterize someone or something as 'beautiful', what kind of value do and should we attach to beauty and appearance, is 'beauty' a universal phenomenon or a cultural construct? Secondly, the meaning and range of the principle of autonomy in the context of changing appearances by medical interventions. For example, how should women's choice to have their breasts enlarged surgically be evaluated in the light of massive media pressure on women to conform to the socially ideal body? A third general ethical issue concerns the goals of medicine. For example, should doctors administer growth hormone to short children with no demonstrable disease? Too short, too fat, too old, there seems to be a medical solution for everything, but do they all belong to the medical realm? If they do, the question must finally be raised whether such treatments should be publicly financed by a social or national health care system.

Ethical issues concerning changing appearance in health care:

1. The value and meaning of beauty
2. The meaning and range of the principle of autonomy
3. The proper goals of medicine
4. The issue of publicly funded health care

### ***General background***

Philosophers and ethicists have written very little on these issues. The description of the personal stories in chapter one and the cases in chapter two, however, illustrate how important appearance is in both private and public life; it raises questions that merit both philosophical and ethical analysis and reflection. We will deal extensively with these issues in part two.

First, we sketch a brief history of plastic surgery and cosmetics as a background for understanding the changing attitudes towards appearance in western culture. Within a century, plastic surgery has become a common and accepted practice. Medical inventions and the introduction of new surgical techniques in response to victims from the first and second



world war, have been important for the development and acceptance of plastic surgery. But cultural developments, such as industrialisation, urbanisation and (im)migration have also influenced attitudes of the general public: in an individualistic consumer society appearance is increasingly important as a means to social and economic security. Furthermore, the emergence of psychological theories about the inferiority complex has also contributed to the acceptance of plastic surgery.

We then describe the existing rules and regulations with respect to the quality of plastic surgery as well as those concerning the reimbursement of plastic surgery. Purely aesthetic surgery is not covered by the social health care system of any country in the EU. Clear and definite as this statement may seem, it is unjust and unreasonable as it stands and not surprisingly, its edges are blurry and exceptions abound; just how to delimit them is a problem all European countries face. Several countries fall back on the same general guidelines. Appearance that falls outside some range of what is socially acceptable, that hamper the possibilities to get or hold down a job, that causes dysfunction or a concern over malignancy, are all frequently paid for (UK, Germany, Belgium, the Netherlands). It seems as if one single criterion underlies these others: suffering, often but not exclusively, caused by social norms.

With this background, the scene is set for an ethical appraisal of the role of appearance.

### ***The meaning of beauty***

Beauty comes in two kinds. In a narrow sense, it can be defined in terms of a person's physical features independent of other characteristics. Physical beauty can be objectively evaluated, without referring to an observer or context. Whether someone is beautiful or not in this sense, depends on biologically anchored universal beauty norms, based on shape, proportion and harmony. There exists empirical evidence which shows a large amount of cross-cultural agreement on which persons are considered beautiful.

Although we acknowledge the importance of physical beauty, we need a broader concept to account for all our aesthetic experiences. Beauty in this broad sense is relative to context and personal identity; it refers to character, performance, and relational capacities. When we evaluate a particular cosmetic intervention, we tend to include the motives, reasons and interests of the person involved.

### ***Autonomy***

Given the fact that norms of appearance are social, can the decision to have plastic surgery ever be anything but a mere reflection of the prevailing social norms? There is a fierce debate among feminists and others about the influence of the media and society in large on women's

decisions to undergo cosmetic surgery. Are those decisions imposed, or are they made autonomously? This is a question that has mainly been dealt with empirically, but a significant part of it is philosophical. Before freedom can be investigated empirically, you have to know what it is that makes a choice a free choice. We argue that what matters is not whether an agent was influenced by factors beyond her control or not, but whether she was able to respond adequately to the circumstances in which she finds herself. Arguably, circumstances may become so oppressive, that no adequate choice is left and hence no freedom of choice either. To forestall such situations, governments and non-governmental institutions should promote a diverse range of beauty ideals.

### ***The goals of medicine***

To decide which interventions belong to the medical realm, and furthermore, whether they should be publicly funded, two criteria are commonly suggested. The first is based on the distinction between diseases and non-diseases, the other on the distinction between treatment and enhancement. Both distinctions are fraught with difficulties. It seems impossible to offer a value-neutral and specific concept of disease and a clear explanation of the difference between treatment and enhancement, be it in terms of temporal difference or in terms of natural processes or normality, is theoretically and practically unfeasible. To think about the role of appearance in health care, we must look elsewhere.

### ***Just health care***

The different rationales for the rules for including plastic surgical operations in a social or national health care system in the different European countries – dysfunctioning, discrepancy with prevailing social norms for appearance, incapacity to get or hold down a job, and suffering – can all be summed up in the last one, suffering, particularly suffering caused by social norms. Disfigurement is a social handicap that can cause considerable suffering. But isn't suffering too subjective to serve as a public criterion?

Since social norms are public, they are not subjective in the sense that they are arbitrary or too personal to base a regulation on. At the same time, it must be accepted that they are not very precise either. In cases where a decision not to pay for a certain treatment is disputed, therefore, a committee of medical and psychological experts could be installed for adjudication. To make the committee's job at all feasible, its members should have recourse to a default list of treatments that are always, sometimes or never paid for. Whether plastic surgery or psychological coaching or a combination of both is the best approach to relieve this suffering in a given case, should not be left to the patient to decide.

**PART I**  
**FACTS, RULES AND MYTHS**

## 1 Three Personal Stories

### *Changing Faces*

I was eighteen years old, just about to leave school and planning to go to university after working and travelling for nine months. It was a cold, drizzly night in early December 1970. I was driving a Land Rover to north Wales with a party of school friends for a weekend's walking. The road to north from Chepstow joins a dual carriageway just outside the town of Usk. The signs seemed misleading, the left-handed bend came up rather suddenly, and before we knew it the Land Rover had toppled over and was skidding on the driver's side across the carriageway.

Someone swore. I had time to think that we'd have to get a crane to set the vehicle on wheels again. Then there was a whoosh as the petrol tank exploded, and flames were everywhere. The others clambered out of the back – largely unscathed – but I was lying in the flames, luckily still conscious thanks to my seat belt, and it took me a few seconds to escape. I was on fire.

My life was probably saved by the prompt action of an ex-nurse and her fiancé in the following car; she sacrificed her white fur coat to keep me warm, and their evening out, to drive me at speed with their car to hospital. After ten days in intensive care at St. Lawrence's Hospital, Chepstow, I was moved to Queen Mary's Hospital, Roehampton, suffering from severe facial and body burns.

During the next four months I was bed-bound and gradually discovering what a dramatic change had befallen me. At first I still had hope that I would quickly be able to pick up my life where I had temporarily left it. But the permanence of my facial injuries, my seemingly incapacitated left hand and severely weakened legs became all too obvious.

Facial disfigurement is not easily mastered, I discovered. My present facial looks were created over the course of four years, as I went through a long series of plastic surgery operations. During that time I managed to take my university place, and in the vacations I went to hospital for more surgery. Beyond surgery I determined to live as full and active as I would have done had I not been disfigured.

Becoming facially disfigured for life brings a whole host of challenges and new battles, but, most of all, it is accompanied from the first day with a fear of being 'written off'. You feel that because your face looks so obviously unattractive, and maybe even suspicious, people will judge your personality on this basis and take you literally 'at face value'. Strangely enough, the fear of being taken just at face value actually haunts even the most handsome people. Robert Redford, the successful American film actor, has experienced a

similar problem. He was recently quoted as saying: 'I've had a problem with my looks right from the start. It's easy for people to write me off as being no more than my looks.'

The process of coming to terms with facial injury or deformity – what I have called 'changing faces' – is ultimately about showing the world that your face alone is in no way indicative of your real worth as a human being. Just because you have been unlucky enough to suffer facial damage is no reason to suppose that you are less of a person. Indeed, quite the reverse may be the case, because your experience will probably make you a better and a wiser person.

The transition from first realising what you have done to your old face to the moment when you really feel happy with your new one is likely to be long and drawn out, maybe taking five to ten years, or more. In some ways, the transformation is never complete, because throughout the rest of your life there will be occasions when, even though you and your immediate circle of family, friends and colleagues have become completely used to it, suddenly your face is one again 'on trial', as you meet a new situation. You will never be able to hide from your disfigurement.

Facing up to the mirror for the first time is a vital step in changing faces – and getting used to looking in a mirror day by day is one of the biggest hurdles in the process of recovery. Can you ever accept that the reflection you see is really you? It is an alien and unfamiliar sight, and there are few recognisable landmarks: your eyes see out in the same way, but your mouth, nose, chin and cheeks are different and rather unsightly.

The image that you see in the mirror is your new exterior – it is you in the eyes of the rest of humanity. Your identity has changed. Now you will need a new passport photo. But, more importantly, your internal picture of yourself will gradually change in the weeks and months to come.

There are very rarely mirrors in a hospital ward for facially injured people. This is quite a sensible precaution, because there is definitely a right time and a wrong time to look at your face after an accident or major cancer operation. This is not to say that looking into the mirror for the first time can ever be less than a shattering experience, but it has been proved in many instances that the timing of that first glimpse may critically affect your entire recovery.

You have to work a lot harder at relationships if you are disfigured. As soon as you discover your new facial identity, you have to start finding suitable ways of expressing yourself that do not rely on the face alone. Your family represents the first group of people on whom you will be able to try this out. By watching them, you can learn why they behave as they do towards you, and this will enable you to develop appropriate ways of conveying yourself to others. This process of learning how to interact actually takes many years, but it usually starts in your relationships with your closest family and friends.

For many victims, the moment of realisation of their disfigurement is often a crisis point when something clicks and the full spotlight shines on their predicament. For me, it was a

first visit to a pub with an old friend – I sat and suddenly felt my disfigurement in all its fullness, as people either stared or asked curious questions like ‘What happened to him?’

Because of their ignorance about the causes of facial disfigurement, people you meet may assume you are suspicious or mentally retarded, or they may try to patronise you and treat you as a poor unfortunate. It is important you squash their misconceptions and assert your worth.

A pro-active approach that offers information will enable you to communicate more easily, but each situation has to be weighed up and assessed. You must develop acute antennae for responding to any given meeting.

You won’t get it right the first time or every time. Trial and error will be required – and so will a good deal of bravery. Sometimes trying out a new ploy may seem almost foolhardy, but if it achieves your aim of being treated normally, or at least not as an idiot, it will have done the trick. For example, I find it hard to imagine myself doing the following, recalled by my brother: ‘I remember going with you to pubs and being aware of conversations stopping and eyes drilling into our backs. In one, you completely disarmed a group of starers with the throwaway comment, ‘Not looking at my best today, I’m afraid.’

If you are young and single, you may fear that facial disfigurement will consign you to the group of unloved outcasts who will never again share good times with the opposite sex. Here again you are falling into the ‘beauty trap’ where physical beauty is seen as a necessary precondition for happiness, especially in marriage. But if there is one thing that TV soap operas truthfully illustrate, it is that wealth and beauty are no guarantee of happiness.

In judging what your life is worth, you will have to take your disfigurement into account. You will see that some activities are more or less barred to you because of your disfigurement, especially, for example, jobs in the public eye. But other doors will open up. You may not be able to go on stage with your disfigurement, but you will be able to empathise with the plight of minority groups of one sort or another in a way you could never have done before.

There are unquestionably minimum social standards of facial acceptability to which it is important the disfigured conform, but you may find it difficult to decide what they are. A few years after my accident, still looking very badly disfigured, I travelled to India. There, and in Iran and Afghanistan, my face was rarely given the slightest attention. Heavily scarred faces are regular sights, as disfiguring diseases and accidents are commonplace, while plastic surgery is not widely available in these countries. I could quite easily have lived and worked there with no further surgery. But on my return, a trip on the London Underground was enough to convince me that I needed more reconstruction to live and work in Britain.

(Adapted from James Partridge, *Changing Faces*)

### *At War with My Skin*

My mother tells me that up to the age of six I had no psoriasis; it came on strong after an attack of measles in February of 1938, when I was in kindergarten. The disease – ‘disease’ seems strong for a condition that is not contagious, painful, or debilitating; yet psoriasis has the volatility of a disease, the sense of another presence co-occupying your body and singling you out from the happy herds of healthy, normal mankind – first attached itself to my memory while I was lying on the upstairs side porch of the Shillington house, amid the sickly, oleaginous smell of Siroil, on fuzzy sun-warmed towels, with my mother, sunbathing.

She, too, had psoriasis; I inherited it from her. Siroil and sunshine and not eating chocolate were our only weapons in our war against the red spots, ripening into silvery scabs, that invaded our skins in the winter. One dabbed oil on; it softened the silvery scales but otherwise did very little good. Nor did abstaining from chocolate and greasy foods like potato chips and French fries do much visibly good, though with many palliations there was no knowing how much worse things would be otherwise. Only the sun, the living god, had real power over psoriasis; a few weeks of summer erased the spots from all my responsive young skin that could be exposed – chest, legs, and face.

Like an obese person, and unlike someone with a withered arm, say, or a port-wine stain splashed across his neck and cheek, I could change – every summer, I *did* become normal and, as it were, beautiful. An overevaluation of the normal went with my ailment, a certain idealisation of everyone who was not, as I felt myself to be, a monster.

Because it came and went, I never settled in with my psoriasis, never adopted it as, inevitably, part of myself. It was temporary and in a way illusionary, like my being poor, and obscure and lonely – a spell that had been put on me, a test, as in a fairy story or one of those divinely imposed ordeals in the Bible.

I recall remarkably few occasions when I was challenged, in the brute world of childhood, about my skin. In the second grade, perhaps it was, the teacher, standing above our obedient rows, rummaged in my hair and said aloud, ‘Good heavens, child, what’s this on your head?’ I can hear these words breaking into the air above me and see my mother’s face when, that afternoon, I recounted them to her, probably with tears; her eyes took on a fanatic glare and the next morning, like an arrow that had fixed her course, she went to ‘have it out’ with the teacher who had heightened her defective cub’s embarrassment. Our doctor, Doc Rothermel in his big grit-and-stucco house, also, eerily, had psoriasis; far from offering a cure out of his magical expanding black bag, he offered us the melancholy confession that he had felt prevented, by his scaly wrists, from rolling back his sleeves and becoming – his true ambition – a surgeon. ‘Physician, heal thyself,’ they’d say to me,’ he said.

I don’t, really, know how bad I looked, or how many conferences among adults secured a tactful silence from above. My peers (again as I remember, which is choosing to remember)

either didn't notice anything terrible about my skin or else neglected to comment upon it. Children are frank, as we know from the taunts and nicknames they fling at one another; but also they all feel imperfect and vulnerable, which works for mutual forbearance. In high school, my gym class knew how I looked in the locker room and shower. Once, a boy from a higher class came up to me with an exclamation of cheerful disgust, touched my arm, and asked if I had syphilis. But my classmates held their tongues, and expressed no fear of contagion.

Of course my concern with my skin was ultimately sexual, the skin being a sexual organ and the moment of undressing the supreme personal revelation and confiding. Yet women, in my limited experience, were not put off by my troubled epidermis; they take, I came to be persuaded, a rather haptic, holistic view of men, in which the voice, the style, the aura, and the three-dimensional effect matter more than surface blemishes. Oddly enough, sexual contentment, whether that of the happily married or the illicitly adored, has never reconciled me to psoriasis or relaxed my wish to combat it; my war with my skin had to do with self-love, with finding myself acceptable, whether other did or not.

Psoriasis keeps you thinking. Strategies of concealment ramify, and self-examination is endless. You are forced to the mirror, again and again; psoriasis compels narcissism, if we can suppose a Narcissus who did not like what he saw. In certain lights, your face looks possible; in slightly different other lights, not. Shaving mirrors and rearview mirrors in automobiles are merciless, whereas the smoky mirrors in airplane bathrooms are especially flattering and soothing: one's face looks as tawny as a movie star's. I cannot pass a reflecting surface on the street without glancing in, in hopes that I have somehow changed.

And yet, I self-consciously wondered, was not my sly strength, my insistent specialness, somehow linked to my psoriasis? Might it not be the horrible badge of whatever in me was worth honouring: the price, high but not impossibly so, I must pay for being me? Only psoriasis could have taken a very average boy, and furthermore a boy who loved the average, the daily, the safely hidden, and made him into a prolific, adaptable, ruthless-enough writer.

The psoriatic struggles for philosophy, for thoughts that are more than skin deep. What could matter less than the integument a skeleton once wore? Despite my skin I have had my fun, my children and women and volleyball games. What concupiscent vanity it used to be, playing midsummer volleyball bare chested, leaping high to spike the ball down into a pretty housewife's upturned face, and wearing tomato-red bicycle shorts that as if casually slid down to expose an inch more of tanned, normal appearing derriere, even to the sexy dent where the cleavage of the buttocks begins! I have preened, I have lived. Between now and the grave lies a long slide of forestalment, a slew of dutiful, dutifully paid-for maintenance routines in which dermatological makeshifts joins periodontal work and prostate examinations on the crowded appointment calendar of dwindling days. For the first time in



my life I own a house within walking distance of a beach, and I walk there scarcely three times a summer. Life suddenly seems too short to waste time lying in the sun.

(Adapted from John Updike, *Self-Consciousness*)

### ***The girl with the bat ears***

Bat ears – whatever hat or cap I wore, it didn't help: they kept sticking out from below. I very much wanted the same ears as my sister. Her ears were situated perfectly neat onto her head and she could create all kind of hairstyles without being bothered by her sticking-out ears. However, once my sister had had the same sticking-out ears as I had, they were even worse! At school the other children teased her very much. In order to stop the teasing my parents decided that she should be operated on her ears. At the time she was four years old. In this way I came to know of the possibility to get rid of these sticking-out ears.

However it took several years before I finally decided to visit the doctor. Due to the fact that I was not extremely teased, I was not in a big hurry to undergo ear surgery. Eventually, at about my sixteenth birthday I decided that I did not wanted to be bothered anymore by my ears: I wanted to able to wear high tails or to wear short hair without having my ears attracting all the attention. My mom and I went to the physician to receive a referral note that is necessary for admission to the hospital. After that it went rather quick: within a short time I had an appointment in the hospital for the first meeting, a medical control and to meet the doctor who would operate me. A few months later the hospital called to tell me that I could be admitted for the operation. It was a bit unexpected though, but I really wanted it and so I was glad I could be served!

Once we were in the hospital I had to swallow pills and put on ointments in preparation for anaesthesia and surgery. In the beginning I thought it was a bit creepy, you never know exactly what will happen, but the nurses explained it all very clearly and that sets a person's mind at ease. Finally it was time: they brought me to the operating room. I did not notice very much of it: the anaesthesia was effective within a few seconds; for a short period the room was whirling round me and since then I can't remember a thing. After the surgery they brought me back to my room where my mother and a lot of friends were waiting for me! That was extremely nice!

The ear surgery took only a day, so I was allowed to go home very soon after the operation. I stayed home for a week because my head was heavily bandaged and that was anything but convenient! By day I was doing well, but I did not sleep very well that week ... no matter how I tried to situate my head, that bandage was pressing against my ears which was pretty painful! After a week I went back to the hospital to pull off the bandage. That procedure was not as easy as I thought it would be. It took a lot of pulling when bandages and

plasters were removed but after a week of bandage it was a relief to be without it. At last I had flat ears! Although they were awfully swollen and purple, I was extremely proud of it. After a week my ears started to look normal again: a successful operation!

Responses then and now were and still are very nice. A lot of people think it is courageous to undergo such a procedure and often they were surprised that I thought it was worth the trouble. A lot of other people are not even familiar with the phenomenon 'ear surgery'. So I have had to explain many times what the surgery involves and why I did it.

Up to now I am very glad that I underwent this operation! I even wore a very short haircut for a while because that was finally possible to do. If I had to choose anew whether or not to undergo this surgery, I would definitely do it again, because it gave me a lot of self-confidence, which I lacked before the operation.

(Written by Hanneke van der Meer)

## **2 Moral issues in health care with regard to appearance**

### ***Introduction***

In the following, we will present you with a pallet of different ‘appearances’: from facial loss to penile enlargement, from short children to bad breath. We will not look at the pathophysiology of aplasia, anorexia, androgenetic alopecia, ichthyosis, halitosis, exogenous ochronosis, Down syndrome or Recklinghausen’s disease. Nor will we present you with a Barnum and Bailey Freak Show featuring the elephant man, the bearded lady, and Florrie, the world’s smallest dwarf. We will look at these symptoms and illnesses from the point of view of those who have to live with them, and on the ethical questions that are involved with changing appearances.

### ***Facial loss***

A good place to start is the face; its importance is difficult to underestimate. A highly developed face is unique to our species. In animals there is a gradual movement from the display and prediction of behaviour to the expression of inner states in the higher primates and man. The development of the face has, therefore, taken place in parallel with the evolution of these complex inner states themselves. Indeed, a mobile expressive face may have been crucial for this intellectual development. One reason for the success of primates has been their development of complex social groups. These require regulation and facial display has a role in this. In humans, further advances have occurred which enable, through mutual regard, ways into other’s minds.

This mind reading should not be thought of as being concerned about cognition alone, in terms of reading thoughts and predicting actions. Intelligence itself may have arisen socially to regulate complex social groups, rather than as a way of storing knowledge of the external world. If social intelligence was required for the development of understanding other’s feelings, then it is difficult to imagine its development without some external disclosure of those feeling states. The face is the embodiment of our emotional, affective selves. As children we seem to learn to calibrate the intensity of our emotional expressions, and possibly the intensity of the expressions themselves from the reactions of those around us. Patients who suffer from Moebius lack abduction of the eyes and facial expression and movement. They never experience feelings on the face and therefore, the emotion itself is experienced less intense. One Moebius patient, James, describes himself as living inside his head, not in

touch with his feelings and not in touch with the world. He can read faces, but he can't give a face in return.

People have an innate desire to enter into other minds. Our species may almost be defined by our inquisitiveness about other's lives and minds and thoughts. The face is the highway into other's minds; without the capacity to show your feelings on your face and to read other peoples minds from their face, we are severely impaired, socially speaking. John Hull describes how he is going blind at the age of 45. The worst is that he gradually loses the memory of the faces: 'The horror of being faceless, of forgetting one's own appearance, of having no face. The face is the mirror image of the self.' Here is a long quotation from his diary:

Yesterday morning I was kneeling on the floor helping Lizzie, (aged 4) get dressed. When she had finished I stood her up and said,

Now! Let's have a look at you.

I held her face lightly between my hands, and gave her a big smile.

Daddy, how can you smile between you and me when I smile and when you smile because you are blind?

I laughed...

What do you mean, darling. How can I what?

With great hesitation she said,

How can you smile — no — how can I smile between you and me — no — between you and me a smile, when you are blind?

You mean, how do I know when to smile at you?

Yes

It's true, darling, that blind people often don't know when to smile... But today I knew you were smiling, darling because you were standing there, and I was smiling at you, and I thought you were probably smiling at me. Were you?

Happily she replied,

Yes!

Suppose, for some reason or other, congenital blindness, Moebius, autism, you did not know how to express your feelings and hence what experiences you would miss out on. It takes less to cry.

(Based on: Jonathan Cole, *About Face* and *The subjective experience of facial loss*)

### ***Looking less Down; plastic surgery for children with Down syndrome***

Since the 1970s, hundreds of children with Down syndrome have had plastic surgery in Germany, Israel, Australia, Canada and the United States. Operations performed include

reduction of the tongue, elimination of the characteristic epicanthal fold by inserting a silicone or rib cartilage implant to raise the bridge of the nose or by an additional surgical procedure directly on the eyelids. Implants are also used to correct receding chins, enhance flat jawbones, and raise cheekbones. Other surgical procedures that are done are the correction of drooping lower lips and correction of both the position and size of the ears.

Surgery for children and adults with Down syndrome raises many difficult ethical issues, concerning consent and their capacity to give it. Operating children with Down syndrome has an additional problem due to the fact that their parents want to prevent unpleasant things happening to their children. According to these parents, suffering in childhood can never be undone. Clearly, the justification given for the surgery is the presumed interest of the child. The important question however is whether and in what sense surgery is in the best interest of the child. One reason in favour of surgery is that it (in particular the tongue operation) may result in a significant functional improvement on speech, eating habits, breathing and less drooling. More empirical research is needed to solve this issue. However, surgery for cosmetic reasons may be more difficult to defend. Plastic surgery may be in the best interest of the child because it will eradicate the typical characteristics of Down syndrome. Discrimination and stigmatisation might be prevented, but the syndrome itself cannot be 'treated' and sooner or later people will notice it. Surgery to let children with Down syndrome look more normal, might even be a disadvantage if people would come to expect more of them than is reasonable given their affliction. Another cosmetic reason for surgery is that parents want to give the child a more attractive appearance. Put differently, they argue that if their child did not have Down syndrome, they would also have chosen cosmetic surgery. This reason may be on the same plane as reasons 'normal' people have for desiring cosmetic surgery. Why shouldn't people with Down syndrome be allowed to undergo cosmetic surgery? Is it unfair to treat children with Down syndrome and normal children

differently? Similar ethical questions can be raised with respect to other children or adults suffering from different syndromes. They too may have specific physical traits that distinguish them from others, for example children with Prader Willi or Turner syndrome.

(Based on: Inez de Beaufort, *Down is Beautiful?*)

***Short people***

*Short people got no reason  
To live  
They got little hands  
And little eyes  
And they walk around  
Tellin' great big lies  
They got little noses  
And tiny little teeth  
They wear platform shoes  
On their nasty little feet  
(Randy Newman)*

Ever since the origin of mankind, short people have been around. In different cultures and periods short people have occupied special posts (as for example the dwarf Miguel Soplillo, confidant of Philips the fourth), they have been the object of entertainment (as Admiral Von Tromp), or they have been treated as a normal variation of the human species. Nowadays, we know a lot more about the causes of shortness. Some of the diseases and disorders causing short stature (e.g. growth hormone deficiency) can be treated by growth hormone in order to stimulate growth. Growth hormone can also be administered to children with short stature where a disease or disorder has not been identified, the so-called idiopathic short children. These children have a normal weight and length at birth, normal bodily proportions, no (clinical) indications of organic diseases, no serious psychosocial problems and a normal food intake. An idiopathic short person can therefore be seen as a healthy person with a stature that deviates from the mean of the population.

The use of growth hormone has evoked ethical debate, especially with respect to the so-called idiopathic short stature. The absence of an identified disease or disorder seems to intensify the ethical questions raised by the use of growth hormone. The treatment may be characterised as an enhancement, a treatment done merely for the sake of appearance just like breast enlargement for women or eye surgery for children with Down syndrome. Does this imply that growth hormone treatment should be restricted to children with growth hormone deficiency? For example, if Sue has short stature due to growth hormone deficiency and Mary due to idiopathic short stature, Sue would receive treatment while Mary would not. Some would argue that although the short statures of Sue and Mary have different causes, Mary might suffer just as much as Sue due to her short stature. The cause of the short stature seems not to be a relevant difference. Therefore, they should both be treated similarly.

Another issue concerns the administration of growth hormone in adopted children. In Sweden and The Netherlands studies are conducted on the growth effect of the addition of growth hormone to GnRH $\alpha$  treatment (Gonadotrophin Releasing Hormone agonist) in adopted children. These children are studied because they have an early puberty, their predicted adult height is short and during treatment with GnRH $\alpha$  decrease in height gain velocity may be observed. Suppose clinical trials show that additional growth hormone treatment results in a considerable increase in height compared to GnRH agonist alone. Does growth hormone treatment belong to the medical realm in this case?

Apart from the issue whether these interventions belong to the medical realm, there are also other important ethical questions such as: who is entitled to growth hormone, how should the danger of medicalisation and stigmatisation be valued, should growth hormone be administered if parents pay for it themselves?

(Based on: Ineke Bolt, *Short stature in ethical perspective*)

### ***Plastic dreams of teens? Plastic and cosmetic surgery for children and adolescents***

*“Mike (a plastic surgeon) who had teenagers of his own, had been listening with increasing impatience. ‘Listen’, he said, ‘all teenagers are crazy. Without exception. – It doesn’t matter what you do to them,’ he says. ‘You can make any change you want because they don’t know who the hell they are anyway.’”* (Goin JM, Goin MK, Changing the body: Psychological effects of plastic surgery. Baltimore: Williams & Wilkins, 1981)

Last year the BBC published the story of the stretch-legging surgery of Emma Richards, a fifteen year old girl from Cornwall. Emma stopped growing when she was 1.44 metre. She desired an operation to stretch her legs to become tall enough to be an airhostess. Due to

safety procedures, all airlines require that their cabin crew personnel have a minimum height (e.g. to be able to reach equipment). The orthopaedic surgeon who operated her said that a psychological assessment preceded the operation. Career aspirations were not the reason to carry out the procedure; it was done out of functional reasons and to make her life better. According to him, Emma was worried about whether she could lead a normal life. Emma's mother said that Emma knows exactly what she wants from life. Nobody forced her; she signed the consent form herself. She is a strong girl who coped well.

The surgery involves breaking the thighbone in both legs in two places. A metal frame links the bones and new bone is created naturally to fill the gap. After the surgery Emma was bedridden for four months. Since then she has had an infection and broken her legs twice. After the operation, her legs were 12.5 centimetre longer, unfortunately still one inch too short to meet the height requirements of cabin crew personnel. However, Emma does not regret the operation and hopes her body will grow eventually one more inch.

Regardless of the nature of the surgery, ear corrections, port wine stain reductions or craniofacial reconstruction, surgical interventions on children and adolescents raise additional moral quandaries. Due to a rapid physical and psychological development, children and adolescents may be more vulnerable than adults who seek plastic and cosmetic surgery. They may be hypersensitive to appearance and inclined to give in to social pressure in order to be accepted by a specific peer group. Do they have realistic appearance perceptions and realistic expectations regarding the surgical intervention? Are they able to make an autonomous decision? Is the adolescent's perspective the only perspective that should count? What is the role of the family? Should they also give their consent?

In many European countries, adolescents of 16 years and older can legally give consent to medical interventions. Children between 12 and 16 years can also give consent together



with the consent of their parents. Are the current legal regulations adequate? How should the surgeon decide whether or not to operate? Should surgeons postpone cosmetic interventions in cases in which there is no clinical need to operate? Are they contributing to a growing obsession by appearance amongst adolescents? Could adolescents take 'the easy way out' and solve feelings of uncertainty or personal problems by means of cosmetic interventions? Answering these questions is difficult because there is little or no research on psychological aspects of plastic surgery on children and adolescents.

(Based on Kuni Simis, *Assessing adolescents and young adults for plastic surgical intervention: pre-surgical appearance ratings and appearance-related burdens as reported by adolescents and young adults, parents and surgeons*, and BBC news: [news.bbc.uk](http://news.bbc.uk), November 2000)

### ***Ageing***

Anne is a 72 year old woman who used to be a ballet dancer, but her career ended when she was 42. She now contemplates to have a face-lift and talks it over with her friend Laura, who is 75, a widow and former literary editor, with three children and seven grandchildren. 'Why exactly is it that you want to have a face lift?' Laura asks her. Anne has always been a beautiful woman, and she still is. Obviously, a 72 year old beauty is not the same as a 27 year old beauty, but 45 years is beyond the reach of even the world's most skilled plastic surgeon. At best, Anne will look 10-15 years younger after the operation. What is the point of looking as if you were 60 when you're in fact 72? Nor does she want the difference between her real age and her apparent age to be too big. When we're very young, most of us want to look

somewhat older, say 16 instead of 13, in order to enjoy the larger freedom of a 16 year old as compared to that of a 13 year old; but not 10 years older. By analogy, when we're older we want to look somewhat younger to be able to bask in the glory that our society bestows on youth; but even Anne does not want to look and hence be treated, as if she was 27. Real age and apparent age may diverge, but on cost of being a living anomaly, it should not diverge too much. There is something ridiculous or pathetic in a 75 year old man with a 25 year old lover, or a 72 year old woman who has had her face lifted so that it has an unnatural look and does not fit the rest of her body and manners. Will the operation make Anne feel 10-15 years younger? If that is what she really wants, fitness training would be much more effective.

General moral issues: is Anne's desire to look younger freely chosen or is it imposed by the cream-, balm- and soap-pushing cosmetic industry, or more generally, by a society who favours youth over old age? If she is so undecided herself, so unsure about her own motives, would it not be a good idea to talk them over with a professional consultant in order to forestall expensive disappointments? If she decides to have her operation after all, then who should pay for it? And finally, in the background, the larger issue of the proper attitude to take towards ageing or generally speaking about natural processes is also playing a role. Is it something we should stoically acquiesce in and accept as something necessarily belonging to life — If you wish to live long, you must be willing to grow old (George Lawton) — or is active protest against undesirable changes to be admired or at least not to be looked down on with contempt? After a certain age, everybody needs glasses for reading, but if God wanted man to read after his 45th, he would have given him better eyes. But no, we consider reading and good eyesight in general so important, that we try to enhance it the best we can with whatever technical means we have. Could it not be that appearance is such an important good to some — it is to Anne, but not to Laura — that they are prepared to go to quite some lengths to keep it up as long as they can?

(Based on: Inez de Beaufort, *Sic transit Gloria mundi*)

### ***Genetic enhancement***

Growing old is not a disease, but it has some unpleasant side effects; what wrinkles were for Anne, baldness is for many men. There are few effective treatments available: wigs are seldom perfect and the effects of medication are variable and difficult to predict in individuals. The most common cosmetic operation in males is hair transplantation; but that is only possible under the condition that enough hair is left that is not too thinly implanted, and even then success is not guaranteed. Although gene therapy is not yet an option, it might become one in the not too distant future. It would be relatively simple, baldness being a

relatively simple 'affliction', and the estimated medical risks, for the patient as well as for future generations, are extremely low.

Just as was the case with face-lifts, gene-therapy for balding raises some general ethical considerations that are well worth considering. One objection, an objection that could be and actually is raised against the background assumption of the whole project Beauty & the Doctor, is that these treatments do not belong to the goals of medicine. The goal of medicine, its primary goal anyway, is to prevent illness, relieve suffering, and forestall untimely death, and enhancing beauty or prevention of the unwanted side effects of the perfectly natural process of ageing could not possibly be classified as belonging to any of these.

Now, even if these activities constitute the core goals, arguably, medicine is not restricted to the pursuit of these core goals; sterilisation and abortion belong to medicine as well. What would be the likely consequences if appearance-enhancing gene therapy would become part of medicine? First, there is the matter of a just allocation of scarce resources. Should we really allocate scarce resources for the concealment of completely natural processes, when people are still dying of AIDS in their twenties, cancer in their thirties, heart attacks in their forties? Secondly, there are social risks to reckon with, tied to a diminished tolerance level for the visually different if people who are visually different become an ever-dwindling minority. In *Changing Faces*, James Partridge who had his face severely burnt in a car accident when he was 18, tells how uneasy he felt in public places in England, and how much at ease in Afghanistan and India during a holiday. There, so many people had a disfigurement as a result of an accident or illness that he was not the glaring exception that he was back home. Cosmetic surgery and other medical interventions aimed at changing appearances, will inevitably reduce diversity and possibly, therefore, the tolerance for exceptions.

(Based on: Guido de Wert, *Somatic Genetic Enhancement: The case of baldness*)

### ***Obesity and eating disorders: more than a feminist issue?***

When it comes down to obesity, alarming figures can be shown. According to the National Institutes of Health (NIH), about 97 million adults in the USA are overweight or obese (NIH, 1998). In some populations of North America obesity affects up to 40% (Jeffcoate, 1998). In Europe, the incidence of overweight for men and women is 49% and 35% respectively, while the corresponding figures for obesity are 16% and 22% (Mathus-Vliegen, 1998). Worldwide there is a rising number of obese children. In 1997, the World Health Organisation declared obesity to be one of the most serious health problems facing mankind.

Eating disorders are an increasing problem in modern industrialized countries. Three different eating disorders can be discerned. Anorexia nervosa (the refusal to maintain a normal body weight out of fear of gaining weight) affects 0,5-1% of adolescent and young adult women. The illness begins between the ages of 13 and 18 years. Approximately 5-10% of the patients are male. Bulimia nervosa is characterized by frequent episodes of binge eating accompanied by emotional distress, and frequent compensatory behaviours to avoid weight gain. The prevalence of bulimia has been estimated at 1-3% of high school and college-age women. 10-15% of the patients are male, more frequent in homosexual men and athletes. Binge eating disorder is a newly described eating disorder with the same symptoms as bulimia but without the regular use of compensatory behaviours. Binge eating is the most common eating disorder, affecting 2-3% of the general population. It has been estimated that 40% of the patients are men. Binge eating is more prevalent among obese people. (Bray, 1998)

The causes of these disorders remain elusive. Factors that could have caused these disorders are psychological factors, sociocultural factors, affective disorders, psychiatric

conditions, biological predisposition, sexual abuse and addiction. The precise relationship between eating disorders and these factors, however, remains unclear.

Obese and overweight people and individuals suffering from eating disorders may suffer from two sorts of problems. They may suffer from health-related problems; according to a report of the NIH, overweight and obesity are conditions that raise the risk of morbidity and high weight is associated with increased mortality (NIH, 1998). Dieting may, however, also result in health problems and liposuction has tragically led to death. In their striving for a thin body, anorexia nervosa patients may starve themselves or commit suicide. Apart from these health risks, they may suffer from appearance-related problems. Due to the thin beauty ideal, overweight and obese women and men suffer from stigmatisation and discrimination.

Mary Litman began dieting years ago, when she was 20. She remembers the moment she resolved to lose weight, at the end of a date with a good-looking young man. He walked her to her door, she recalled, and said, "It's a good thing you have a pretty face because you're really fat". (The New York Times, 18 October 2000)

I had such a hatred for myself, she said. And you don't realize the rejection that goes with being heavy. People are prejudiced. I understand. But it really hurts. They hit you in the soul. (The New York Times, 12 October 2000)

With respect to eating disorders, important questions are why these disorders predominantly afflict young women and why they have become more common in modern industrialized cultures. (BMA, 2000)

Critics of the contemporary slender body ideal have emphasised the slender ideal as being oppressive and dangerous to women. According to some feminist critics, the slender body ideal is culturally constructed and productive of eating disorders and obesity. In this perspective, a woman embracing this ideal and choosing a diet is at the least problematic and her choice cannot be classified as autonomous. How should one interpret the choices of women to diet and other strategies to get a slender appearance: are they cultural dopes or autonomous decision-makers? What is the role and responsibility of the media? Are eating disorders solely a feminist issue? (Un)fortunately also men seem to become increasingly concerned about their body shape. They may be preoccupied with muscularity and obsessed in trying to gain weight without gaining fat. This is called muscle dysmorphia (popularised as the Adonis complex), including "cognitive distortions of body image, abnormal eating attitudes and obsessive thoughts about muscularity, behavioural manifestations in the form of anabolic steroid misuse and excessive exercise, and marked functional deficits in terms of social avoidance and occupational functioning" (Morgan, 2000).

(Based on: Ineke Bolt, *Bumps, bulges and tummies. The moral meaning of the obese and the thin body*)

### ***Ethnic changes***

Since the emergence of cosmetic surgery, individuals have not only been trying to enhance their appearance but also to eradicate their ethnic characteristics. Throughout the 19<sup>th</sup> century, surgical procedures were done to enable Jewish people to pass as a member of the dominant ethnic group. Nowadays, an increasing number of Asian women are undergoing double eyelid surgery to make their eyes look wider and probably to give them a more Western look. By the early 1960s, 200.000 women undergo a double eyelid operation in the 108 clinics in Tokyo each year. (Haiken, 1997: 203) According to the American Society of Plastic and Reconstructive Surgery, 39.000 Asian American were operated by surgeons certified by the American Board of Plastic Surgery in 1990. (Haiken, 1997: 207) This number does not include the Asian Americans who go to other practitioners or go overseas. African Americans also have begun to alter their noses and lips through cosmetic surgery. Although cosmetic surgery is not yet widespread among African Americans, they have used skin-bleaching products on a large scale since the beginnings of slavery.

“I don’t want to be black, I want to look nice”, says Aheraa Dede in a decided tone. Aheera lives in The Netherlands but comes from Ghana. She is 29 years old and has two children from different partners. She lives together with a friend, a white male. Eight years ago she started to use skin whiteners. While in Ghana, she did not use skin whiteners, although she knows several women in Accra who do. She denies that white people influenced her decision to whiten her skin. She says that she uses them because black men prefer women with a light skin colour. A light skin is supposedly more elegant. She does not want to be white; she has her own beauty ideal: the appearance of people with mixed blood from the Caribbean and the United States. Their light curly hair moves smoother and their skin colour is more acceptable. To get a quick and visible result, Aheera mixes together several creams

with different textures. She feels more comfortable having a light skin but she is also a bit anxious. Her skin around her eyes is red, thin and swollen and her cheeks are full of infected pimples. She doesn't dare stop using the skin whiteners in fear of becoming blacker than she already was and of losing her boyfriend. He is unaware of her skin whitening. Being asked whether her life has been improved by skin whitening, she answers laughing that a cleaning company employs her temporarily, that her children are going to school every day and that she has a white partner. Worrying about her skin is all in the day's work. (Gomes, 1996)

Skin whitening or lightening products are extremely popular among non-white skinned women in countries such as India, the Philippines, Africa, and in Western countries. According to a dermatologist "they come next to toothpaste on any young Filipina's essentials list" (Easton, 1998). Skin whitening products with fancy names such as Dr. Fred Palmer Skin Whiteners, Crusader Skin Toning Crème, Fade Out, and Venus the Milo, are sold as creams, lotions and soap. Many of these cosmetics contain hydroquinone. This bleaching agent is dangerous when it is applied longer than six weeks and in high concentrations. Side effects are confetti-like depigmentation, discolouring of the nails, and exogenous ochronosis: lumpy black and ochreous spots (Menke et al, 1992). This complication can be seen on body parts where the agent is frequently applied: the forehead, temples, nose, lower jaw, and parts of the neck. The bleaching agent can also result in vitiligo: unwanted white spots. It may also be a cancer-causing agent. The application of sunblockers and corticosteroids may lead to some regression but an adequate therapy is missing. In serious cases, the disorder is irreversible. Studies have showed that a low concentration of hydroquinone (2% or less) can also lead to complications (Hardwick et al, 1989). Recently, the European Committee prohibited the sale of skin whiteners that contain hydroquinone (it is only obtainable on prescription). However, bleaching agents are easy to come by in Afro-Caribbean Toko's.

Skinwhitening is not a recent phenomenon. Since the early years of slavery, especially women have used skin whiteners. According to critics of these practices, these women are victims of a racist and capitalistic society and a white Anglo-Saxon beauty ideal. Women using these products want to get and to keep (better) jobs and a relationship. Others question whether there is a relevant difference between skin whitening by black women and sun tanning by white women. Are they not on the same moral plane if the side effects are comparable and the women adequately informed? What is the moral difference between all the diverse interventions to change ethnic characteristics, be it eyelid surgery or nose jobs?

(Based on: Ineke Bolt, *Ebony and Ivory*)

### ***Cosmetic dentistry: the perfect smile***

Facial appearance figures highly in our modern society and in human behaviour. The eyes and the mouth are important factors in human communication; while communicating, people tend to focus their attention to the eyes or the mouth of the person talking. Eyes as well as the mouth are instruments for emotional expressions such as joy and sadness. The importance of the mouth is also pictured in magazines and other media. Not only do pictures show the perfect smile, but also how to get it: what treatments are available and what outcomes can be achieved.

Dentists are increasingly confronted with demands of people that exceed the patients dental health: some desire a dental look which is in concordance with a model's look and others desire a specific cultural dental look. These demands may bring the dentist in a moral dilemma between respecting the client's wish and promoting her welfare.

When those values are not in harmony, problems arise. For instance, tetracycline staining cannot be bleached or polished off; treatment therefore involves the removal of the sound tooth tissue. This treatment carries risks such as transient discomfort, fracture or periodic replacement of veneer or crown, pulp death, loss of tooth, infection. If the patient is adequately informed and still desires the treatment, probably many dentists would provide it. The patient's dental look will be restored to one of normal appearance.

Problems however arise in cases where the two values are in conflict. This may happen when:

1. Conditions, such as the oral hygiene and payment, preclude the provision of a treatment that is needed and wanted by the patient. For example, the treatment of grotty teeth meant to improve appearance but which is detrimental in the short or long term. Another example concerns patient's desiring crowns to improve appearance but who can't afford it.
2. The two values are also in conflict when the patient desires a treatment for which no physiological or biological need exists. For example for career reasons a client may wish to



have whiter teeth and teeth that are all of the same shade. It is technically feasible (by providing him veneers) to respect the wish of the client. This procedure would however carry the same risks as the treatment of tetracycline staining. A similar request may be motivated by a desire for personal adornment or social esteem. A pop star, Mick Hucknall of Simply Red, may be an example in this case. He requested to place a jewel-encrusted crown on one of his front teeth. This intervention would carry the same risks as those already mentioned. The desire to place golden crowns on their teeth is prevalent amongst Chinese and Caribbean communities. If there is no clinical need, questions arise whether these choices should be respected. Should dentists refrain from interventions such as these? Are they immoral or should they be allowed on the condition that the clients pay for them themselves? Should they be interpreted as requests for consumer goods or may a psychological need be at stake in some cases?

(Based on: Andrew Bridgman *Cosmetic dentistry: care or commodity*)

### ***Offences to the nose***

How one appears is not only a matter of how one looks; appearance pertains to at least four senses: sight, sound, touch, and smell. We all have a personal sphere that we don't want to be invaded: we don't like to be stared at by strangers, we are annoyed by ghetto-blasters in trains or on the beach, we keep a certain distance when in company with others in confined spaces such as elevators, and we resent other people's smells. Smells in particular are offending, because they are so pervasive and difficult to evade; you can look in a different direction if what you see displeases you, but you can't just smell the other way if your neighbour stinks of sweat and garlic.

Because we as a matter of fact have a personal sphere, we recognise some sort of duty to respect it, not to intrude on it, and if we happen to intrude on it all the same, we feel ashamed or at least we ought to feel ashamed. The cosmetic industry thrives on this fear of making ourselves a nuisance, smell-wise, and we spend huge amounts of money on soap, deodorant, perfume, after-shave, and tooth paste. What is considered to smell bad is partly idiosyncratic — a matter of personal taste — partly culturally linked — the cauliflower versus curry issue — and partly it is universally agreed upon — we are biologically programmed to abhor the smell of dead human bodies. But to live up to a certain minimal standard of cleanliness, be it a culturally determined one, is a duty toward others and toward ourselves; respect and self-respect demand it.

So much the worse for those, who for no fault of their own, cannot keep this minimal standard, people who suffer from various diseases, from abnormal sweating, via bad breath (halitosis) to an affliction which makes the patient smell of rotten fish all over his body (ichtyosis). Living with these diseases can be extremely stressful and make all social life almost impossible.

(Based on: Inez de Beaufort, *Offences to the nose*)

### ***Living with a prosthesis***

People can deal with the fact that they miss a hand in different ways. In 1998 Clint Hallam from New Zealand received a French donor-arm. However, later Hallam did not want to keep 'his' arm any longer because of poor hand function and the side-effects of his immuno-suppressive regimen. His arm showed serious symptoms of rejection and is 'de-transplantated' in February 2000. Hand transplantation is not a successful technique yet and most people missing a hand have to choose between 'taking it as it is' or to conceal the fact of a missing hand or arm by wearing a 'natural', flesh-coloured prosthesis. If children miss a hand, they and their parents may choose a special eye-catching prototype of an artificial hand: an advanced hand prosthesis that is very showy and bright coloured and has the image of a funny toy. This prosthesis has been developed at Delft University of Technology in the Netherlands. Researchers wanted to design a prosthesis that would be desirable and attractive for young children. They seem to have succeeded, because even teenagers like its appearance.

A traditional and a special prosthesis differ in an essential way: both prostheses are functional, but they differ with respect to beauty-norms. Whereas the traditional prosthesis conforms to a norm of physical, natural beauty, the special prosthesis conforms to a norm of its own. Which prosthesis people prefer, seems to be a matter of taste: some would love it; others would think it is awful. One could, however, argue that a choice for a (particular) prosthesis is not solely a matter of personal preference (and a private matter), but that it goes

beyond the sphere of taste. To take a prosthesis as beautiful may imply that the device is seen as appropriate for this individual in his or her situation, that it belongs to him or her. Judgements like these seem therefore to involve more than just an expression of a personal preference. Put differently, the issue is whether the design and the choice to wear it, is morally neutral or not.

Do choices to wear a prosthesis and a certain kind of prosthesis raise questions of personal identity and the value of bodily difference? And if that is the case, what are the implications for doctors, parents and their children? Most parents prefer a traditional prosthesis for their children in order to give them a normal appearance. Children often hate wearing prosthesis and like to live without one. What should be done?

(Based on: Medard Hilhorst, *'Prosthetic fit': personal identity and the value of bodily difference*)

### ***Breast augmentation and the silicone issue***

Breast augmentation is one the most popular forms of cosmetic surgery. This form of surgery raises different questions such as what the motives of women are. Questions are raised concerning the side-effects and the risks of the silicone implants. The chance of side-effects is estimated to be between 30 and 50 % (Davis, 1995, 27). The more common, usually temporary, side-effects are the possible loss of nipple sensation, painful swelling or congestion of the breasts, hardening of the breasts and the occurrence of asymmetrical breasts. A more serious side-effect is capsular contraction, which occurs in nearly 35% of the cases: the forming of a capsule of dense, fibrous scar tissue around the implant (Davis, 1995,

27). As a result, some women get slightly firmer breasts, others however experience severe discomfort, pain and a bizarre appearance of the breast. A firm massage by the surgeon may break up the tissue, which is quite painful for the patient. If massage does not help, removal of the implants is necessary. Finally, the envelope containing the implants may rupture or may leak silicones into the body. Controversy has been raised by the question whether silicone implants cause autoimmune or other illnesses.

Due to the popularity of breast augmentations, the controversy regarding the safety of silicones could have a tremendous impact. It is estimated that one to two million women wear silicone breast implantations. About 25.000 to 30.000 women in The Netherlands wear them (Gezondheidsraad, 2000). Although there is no scientific evidence that silicone implants causes any form of systemic disease, an explosion of personal claims followed, resulting in a \$ 2.5 billion compensation deal for 90.500 women worldwide. According to Angell, this controversy could lead to such a disaster because three professions failed: law, medicine and journalism. The US legal system invites this sort of abuse, while the media did not provide a critical analysis of the cases during the early stages, and doctors co-operated as expert witnesses and often made dubious diagnoses (Angell, 1997).

Another question concerns the reasons and motives of the women involved in breast surgery and whether they are able to make a free, autonomous choice. Some underline the pressure to undergo cosmetic surgery. According to these critics, the pressure manifests itself in numerous ways: through advertising, articles in the media, personal stories in talk shows and the fashion industry. The images produced are not ideologically neutral, but are suffused with the dominance of gender, race, class and other cultural categories. These cultural representations homogenize: ethnic and sexual differences are smoothed out to the advantage of the Anglo-Saxon beauty ideal. Moreover, these homogenized images normalize: they serve as examples of how one should be. Put differently, women undergoing cosmetic surgery

conform to a norm that is imposed on them by gendered, racist and class ideologies. The conditions of genuine choice, therefore, have not been met and women in these practices are not making choices of their own (Bordo, 1995). Others, however, stress the autonomous agency of women undergoing cosmetic surgery. Kathy Davis has investigated the decision making process of women contemplating to undergo cosmetic surgery, mostly women desiring breast augmentation or reduction (Davis, 1995). The women Davis spoke to described years of suffering before even thinking about consulting a cosmetic surgeon. Their suffering, so convincingly rendered, has pervaded their whole life: when buying clothes, when going to the beach, when doing sport, when having sex. They have been constantly reminded that their breasts were too big or too small. One woman with big breasts was constantly being treated as a sex-bomb; big breasts are supposed to be sexy, whether you want it or not. One can however also suffer from the opposite. A woman with small breasts tells about her experience in a hospital after giving birth to her first child. Lying in a hospital bed, feeling one hundred percent women, the nurse washing her body, blurts out: 'Gee, you're flat as a pancake, aren't you?' Whether being cast in the role of a sex symbol or not coming up to the image of a 'real' woman, one's sense of self is influenced by the expressions of the ones around you, and this may lead to a low self-esteem and suffering of the people involved.

According to Davis these women wanted to put an end to their suffering. They wanted to become ordinary rather than beautiful. Cosmetic surgery had come to be the only way to achieve their goal. Davis does not deny that there is pressure on women to change their bodies, but she stresses women's autonomous agency: they are informed, know the consequences of their choices and are not coerced by near ones. Though she wishes circumstances would be otherwise, women make the best of it given these circumstances.

How does the beauty system exert pressure and is the pressure so strong and of such a quality that women's choices are not their own? This controversy is not (solely) to be solved in an empirical way; underlying this controversy is a conceptual problem about freedom and agency. In chapter six we will deal with this question. Considering their suffering one should also face the issue of reimbursement of breast surgery.

(Based on: Christopher Ward, *Ethical Issues in the Breast Silicone Implant Controversy* and Henri Wijsbek, *The Pursuit of Beauty*)

### ***Penile enlargement***

If penile enlargement were safe and the promised results technically attainable and stable, what ethical issues would remain? It is sometimes suggested that men who seek penile enlargement are deluded or sexually obsessed. What do we actually know about the motives

for wanting a larger penis? For one thing, the penis plays an important role as a phallus, a symbol of masculinity and male power. On this interpretation, penis enlargement surgery is not primarily about sex, but about power and self-esteem. There is some evidential support for this claim:

There is an advantage to having a large penis that is sometimes difficult to explain, says Jerry.

In business, I come in contact with men primarily because of the line of work I'm in. And I know when I'm talking to another man that 95 percent of the time I've got something that he does not have. There is a self-confidence that comes from realising that. I never had this procedure so anyone could see it — that was never important to me. What is important is that I know it is there, and that makes all the difference.

Closely aligned to this interpretation of the reasons for penile enlargement surgery is the so-called 'locker-room syndrome' explanation. The claim here is that the man with the small penis feels embarrassed in situations (like the locker room) where his penis can be immediately compared to the penises of other men.

A second reason for having penile enlargement surgery is that it is (seen as) important for immediate sexual attraction and a man's ability to be an effective partner. There is little research on this subject, but the answers that are given fall neatly into two categories: size does not matter, but skill does; and yes, size matters.

Either reason, boosting your self-esteem or seeking a more satisfying sexual life, seems perfectly legitimate and certainly not a sign of delusion or of sexual obsession per se.

And are surgeons who perform it incompetent freebooters? Does a man wanting this kind of surgery have a reasonable chance of getting unbiased information about success rates, discomfort and complications? Not really. There simply is no unbiased information available, but the information that is available in the more respectable part of the literature seems to

indicate that penile enlargement surgery is not risk free. It could thus be argued that the present state of penile enlargement surgery is unethical, not because of any inherent problems in the aims of the surgery, but simply because doctors performing these operations neglect their duty to enable rational decision making by their patients.

The real problem seems to be that this kind of operation takes place in a sector of private medical practice that is almost totally unregulated, and where the incentive to assess and make public data on outcomes and complications. This leaves the consumer of penile enlargement in a very vulnerable position without any real possibility to gain the information that is relevant for choosing a provider of these services.

(Based on: Søren Holm, *Size matters — Penile enhancement as a test case in the ethics of plastic surgery* and Kathy Davis, *A dubious equality*)

### ***Doctors and schmometers: the wild west of cosmetic surgery***

In the realm of medicine and appearance, problematic cases may arise due to the current practice of the private cosmetic (surgical) clinics. In fact, these clinics are largely untouched by the rules and regulations of the publicly funded health service. In this situation, the private clinics' medical personnel are free to practice without adequate training and monitoring, peer review, audit, and quality controls. Instead, they are under the influence of financial incentives and are providing misleading information. Beauticians receive financial rewards for every client they refer to the private clinic. The following clinical vignette illustrates the serious consequences that may result from this practice.

A man of 22, called John came to see me to discuss cosmetic surgery. He came from a simple background and has a modestly paid clerical job. He lives at home and is unmarried and has few friends. At the age of 16 he underwent a rhinoplasty with the motivation of not just

enhancing his appearance but enhancing his opportunity to make friends. The surgeon took no account of his personal and social background nor did he consult with his general practitioner. The result was not to his satisfaction. However, the surgeon refused to do any more work or to make further appointments.

However at the age of 20 John returned to the original surgeon to ask for a facelift and correction of prominent ears. These entirely inappropriate operations were carried out for a huge sum of money without, once again, taking into account his background or information from his general practitioner. As could be expected in a young man of that age the result of the facelift was not only unsatisfactory but made him look less attractive with the added scarring and asymmetry of his face. The surgeon refused any further appointments.

He came to see me with the possibility of undergoing further revisional surgery when it was glaringly obvious that he required psychological assessment and has since been referred to a clinical psychologist who has a special interest in dysmorphic disorders. The psychologist has subsequently provided counselling and therapy in order to enable him to understand his predicament and has very helpfully provided the service which he should have been provided right from the start in order to avoid the useless, harmful, extravagant surgery to which he was submitted and which he could not afford. It is likely that he will require some revisional surgery in order to treat obvious complications but this will now be provided within the public sector as it has been argued by his general practitioner that this can be justified.

(Based on Christopher Ward, *Implications of Rationing in Provision of Cosmetic Surgery*)

### ***Inventory: summing up the ethical issues***

The above-presented cases differ in significant and profound ways: some concern changing the appearance of children, either mentally deficient children as in the case of Down syndrome, or children who are too short for their age; others involve requests of elderly people who suffer from their old appearance (wrinkles, baldness), and yet other cases reflect the problems of specific ethnic groups, such as skin whiteners used by black people or eye surgery requested by Asian people. It is also interesting to remark that most of these cases are gender neutral: short children, Down, dentistry, smell, prostheses, and the general importance of the face may serve as examples. Some, of course, are not gender neutral; although figures are impossible to get, skin whiteners are probably more often used by women than by men, and eating disorders are also more frequent in women. But then again, men are more often afflicted by baldness than women, and they are catching up on cosmetic surgery to counter the effects of ageing.



But although each case is unique, there are some general ethical issues they all have in common. We have discerned four: The first concerns the value and meaning of beauty. What do we mean when we characterize someone or something as ‘beautiful’, what kind of value do and should we attach to beauty and appearance, is ‘beauty’ a universal phenomenon or a cultural construct? Secondly, the meaning and range of the principle of autonomy in the context of changing appearances by medical interventions. For example, how should women’s choice to have their breasts enlarged surgically be evaluated in the light of massive media pressure on women to conform to the socially ideal body? A third general ethical issue concerns the goals of medicine. For example, should doctors administer growth hormone to short children with no demonstrable disease? Too short, too fat, too old, there seems to be a medical solution for everything, but do they all belong in the medical realm? If they should, the final question must be raised whether such treatments should be publicly financed by a social or national health care system.

Ethical issues concerning changing appearance in health care:

1. The value and meaning of beauty
2. The meaning and range of the principle of autonomy
3. The proper goals of medicine
4. The issue of publicly funded health care

Philosophers and ethicists have written very little on these issues. The description of the personal stories in chapter one and the cases in chapter two, however, illustrate that appearance is important in both private and public life and raises questions that need philosophical and ethical analysis and reflection. We will deal extensively with these issues in part two.

In the remaining chapters of part one, we first sketch a brief history of plastic surgery and cosmetics as a background for understanding the rise of and the changing attitudes towards plastic surgery and cosmetics in western culture. This chapter shows that plastic surgery is increasingly regulated; in the next, chapter four we describe the existing rules and regulations with respect to the quality of plastic surgery as well as the rules concerning the reimbursement of plastic surgery.

### 3 The beauty culture: plastic surgery and cosmetics

Within a century, plastic surgery has become one of the most important medical specialities. Moreover, the attitude towards the practice of plastic surgery has changed. Instead of being disqualified as a dubious practice of quacks and beauty doctors, plastic surgery is nowadays a common and accepted practice. How did this happen?

As to how this change took place, different explanations may be given. Most plastic surgeons locate the origin of plastic surgery in World War I. According to their description of the well-spring of plastic surgery, antecedents of plastic surgery can be traced back to earlier centuries and different cultures. Reconstruction of noses are described as early as 600 B.C. by the Hindu surgeon Sushruta, who reconstructed the noses of men whose noses were amputated as a punishment for adultery. In the 16<sup>th</sup> century, Ambroise Paré made an important contribution to the development of the principles of wound-healing and treatment. At the end of the 16<sup>th</sup> century, the Italian professor of surgery, Tagliacozzi, described a reconstruction of an amputated nose using a flap of the arm in his book *De curtorum per insitionem*. The introduction of anaesthesia and antisepsis at the end of the 19<sup>th</sup> century was important for the development of plastic surgery. World War I, however, is seen as a turning point; that period saw the birth of plastic surgery as a medical profession. In response to the need of the victims of modern warfare, many of them suffering from facial injuries, surgeons were able to improve surgical techniques and expertise. Morestin in France was one of the pioneers in plastic surgery. Special plastic surgical units were set up in the United Kingdom and France at the beginning of World War II. During World War II, McIndoe founded a Royal Air Force reconstructive surgery unit in East Grinstead where he initiated the Guinea Pig Club. The Club's goal was to reconstruct the soldiers physically and psychologically and to get them back in the air as soon as possible. (Gilman, 1999: 162) In Germany, professor Joseph treated facial injuries and burn wounds. Joseph, who is considered as one of the pioneers of aesthetic surgery, developed techniques for nose surgery and breast reduction. As a result of the war and the reconstruction of faces of European and American soldiers, the acceptance of cosmetic surgery grew. During the war, Americans heard and read about the miracles of plastic surgery; after the war it sooner found its way in the American than the European culture (Haiken, 1997: 35-36).

According to Haiken, the history of plastic surgery should not be located solely in a medical context. To understand the rise and changing attitudes towards plastic and cosmetic surgery, it must be viewed in a cultural context as well. Haiken argues that interest in plastic and cosmetic interventions arose well before the 1920s. Nasal operations for example were

performed in the late nineteenth century. Besides reduction of too big or large noses, most of these operations were meant to build up the so-called saddle-nose. A saddle-nose can be caused by trauma, abscess, or infection or it can be inherited. The more common causes in these days, however, were syphilis, scrofula and lupus. Due to this association people having a saddle-nose were the object of stigmatisation. Moreover, anti-Semites labelled a large nose as typically Jewish. Specialists trying to correct these kinds of noses were aware “that they were responding to a cultural, as well as a medical, problem” (Haiken, 1999: 20). A popular substance to build up saddle-noses was paraffin. Because of the side-effects (its tendency to migrate and the development of wax-cancers) the practice of injecting paraffin was abandoned by 1920.

Cultural developments in the early twentieth century such as industrialisation, urbanisation, immigration, and migration have had an important influence on the attitudes towards appearance and plastic surgery. These developments have changed the nature of social relationships. Identity is no longer grounded in traditional institutions such as the family, but dependent on self-presentation in ever-changing social settings (Laermans, 1993). Moreover, a new visual beauty culture arises: between 1921 and 1941 the movie business became increasingly popular. In the same period a mass market for cosmetics was generated with a national system of mass production, distribution, media-based marketing and national advertising (Peiss, 1998). A significant number of women were working in advertising, marketing, sales and the media. By 1940, cosmetics were widespread among women and an important sector of the economy. Facing the mass quest for beauty, plastic surgeons realised that many women would turn to plastic surgery. Some surgeons restricted their practice to reconstructive surgery because they wanted to distinguish themselves from the so-called quacks and beauty doctors. Others turned to cosmetic surgery and tried to incorporate it into the medical realm. According to Haiken, these surgeons could find a justification for their cosmetic practice in two cultural developments: 1. the social and economic requirements of the consumer culture, and 2. the interest of American people in new psychological theories, such as the inferiority complex.

During and after World War I, plastic surgery was justified by referring to the social and economic value of appearance; reconstructing the faces of wounded soldiers could give them the opportunity to achieve economic self-sufficiency. The social and economic importance of physical appearance was emphasized during the Depression in the 1930s. In a competitive, individualistic world where first impressions count, plastic and cosmetic surgery were valued as a means to social and economic security. Justifying their practice by referring to the economic value of appearance however seemed to locate plastic surgeons in the same realm as other beauty servers, such as hairdressers and beauticians. Many plastic surgeons resisted this kind of association and tried to keep their practice in the sphere of medicine. Haiken argues that the popularity of psychological theories enabled these surgeons to “portray their

speciality as a more serious, and a more medically necessary, practice than it might otherwise have seemed” (Haiken, 1999: 108).

Psychological theories gained credibility as a new science during the inter-war years. Psychology, psychiatry and psychoanalysis were popular among academics, practitioners, the general public and plastic surgeons. Adler’s theory of the inferiority complex was well-known by the 1920s. Adler’s thesis was that feelings of inferiority were quite natural in young children due to the fact that they were lacking power in relation to adults. These feelings could become negative in the process of upbringing, if for instance a child was frustrated in undertaking tasks, but in a normal maturing process these feelings could change in a successful “striving for mastery” (Haiken, 1999: 111). During the pre-Depression period, the inferiority complex was used to explain daily personal and national events, such as Americans’ buying patterns. Plastic surgeons were also attracted to the theory about the inferiority complex and used it in justifying their practice. A physical anomaly could result in abnormal psychic behaviour and endanger mental health of individuals. It could be seen as “psychiatry with the scalpel”. (Haiken, 1999: 108) Plastic and cosmetic surgery, therefore, no longer remained in the realm of vanity but was incorporated in the realm of mental health. It seemed the solution for difficult issues such as the difference between reconstructive and cosmetic surgery.

After World War II, the beauty industry developed into a booming business; new cosmetic products were pushed onto the market. Plastic surgery also showed a significant increase in specialists and clients; in 1960 the number of specialists had tripled since 1940. In 1948, 15.000 Americans had undergone plastic surgery, compared to more than 130.000 in 1958 (Haiken, 1999: 136). New antibiotics and surgical techniques that came out of the war contributed to the expansion of plastic surgery. A lot of publicity was given to these new techniques, also by plastic surgeons themselves (the American Board of Plastic Surgery). Face-lifts in particular came into focus after World War II. Post-war prosperity made facelifts available to the middle class and were valued as a proper tool in keeping a youthful appearance.

Since the 1960s, cosmetic surgery is no longer a typically American phenomenon. Surgery techniques are also imported by American surgeons, among others liposuction that originated in France. Starting with nose-jobs, followed by facelifts, breast augmentation, tummy tucks, liposuction, and nowadays operations of Down syndrome, pectoral implants and penile enlargements all belong to cosmetic surgery. The number of clients and surgeons has increased and a more positive attitude has developed.

However, some questions remain. For example, the battle between beauty doctors and quacks on the one side, and plastic surgeons on the other is still going on. Attempts at organization and control resulted in the founding of the American Association of Plastic Surgeons in 1921, the American Society of Plastic and Reconstructive Surgeons in 1931, and

the American Board of Plastic Surgery in 1937. The Board selected their aspirant-members and developed a program for education and training followed by an examination. Board certification made it possible to discern who was and was not a plastic surgeon. The Board formulated regulations, but was not able to enforce them. Those practitioners who operated outside these limits, did not eschew publicity and were known by the general public as plastic surgeons.

In a way, control problems still exist today in the US as well as in Europe. Advertising may be a case in point. In the USA, advertising by physicians is permitted since 1982 (Haiken, 1999: 294). There are more advertisements in the field of cosmetic surgery than in other specialities. Among them, a lot of misleading advertisements are published. Although several organisations have tried to formulate policies for advertising, they are hardly successful in enforcing them. European organisations in the field of plastic surgery are struggling with the same kind of problems. Although plastic and cosmetic may have started as a typical American phenomenon, affiliated with the American tradition of self-improvement, nowadays these techniques are practiced worldwide. As a result, the issues linked to plastic surgery confront European and other continents as well. Except for advertisements, these issues concern the definition of plastic surgery. Plastic surgery is still seen as synonymous with cosmetic surgery by the general public. Quality control by professional organisations seems to be hard to realise, especially with respect to private clinics.

### ***Summary***

Within a century, plastic surgery has become a common and accepted practice. Medical inventions and the introduction of new surgical techniques in response to victims from the first and second world war, have been important for the development and acceptance of plastic surgery. But cultural developments, such as industrialisation, urbanisation and (im)migration have also influenced attitudes of the general public: in an individualistic consumer society appearance is increasingly important as a means to social and economic security. Furthermore, the emergence of psychological theories about the inferiority complex have also contributed to the acceptance of plastic surgery.

Although attitudes have become more positive in the USA as well as in Europe, some negative attitudes seem to stick, especially attitudes towards purely cosmetic surgery. For example, the general public still associates plastic surgery with cosmetic quacks, while plastic surgeons stress that their work involves much more than just cosmetic surgery and moreover, that cosmetic surgery should be submitted to regulations. However, policies and regulations with respect to education, certification, advertising practices and quality control are difficult to enforce.

## 4 Rules and regulations

### *Plastic surgery and public health care systems*

There are two obvious reasons for regulating, one way or the other, the health care treatments that should be covered by some kind of public funding. The first is financial: ministries of public health are accorded a certain amount of money and should spend it as effectively as possible. The second is concerned with justice: those insured must know what claims they can rightfully make, the claims must be granted equally for all, and there must be some way to deal with free-riders. These are reasons of the most trivial and obvious kind, completely uninteresting as they stand. But as soon as you try to formulate some substantial rules for actual use, controversy is likely to arise immediately.

Generally speaking, purely aesthetic surgery is not covered by any insurance system in the EU. But this is a rule with at least two general exceptions: suffering and unemployment caused by appearance. In the UK, some purely aesthetic treatments are offered within the NHS, provided the patient suffers from severe psychological distress (among others abdominoplasty, benign moles or naevi and rhinoplasty) or is experiencing difficulties in finding employment due to appearance (tattoo removal). In Belgium and Germany, the possibility to find or hold down a job is also a criterion for being eligible for some form of public funding. In this chapter, we will look somewhat closer at how these general rules are actually applied.

In the Netherlands, collective funding for plastic surgery was first regulated in 1970. At that time, there were few plastic surgeons, and the Medical Insurance Board found it fit actually to encourage the social health care funds to be more generous with compensation for this kind of operations. Accordingly, the first guideline that was promulgated, read as follows:

The social health care funds can reasonably be charged with a treatment, if the operation can be expected to have a positive effect on the patient's personal problems. (Starmans, 1988: 22)

Of the three regulations that have hitherto been in force, this is the only one that unambiguously achieved its goal: the number of operations rose drastically and so of course did the costs. Medical officers working for the health care funds who tried to restrict the claims in the years that followed, had no leg to stand on. Literally every treatment could be expected to have *some* positive effect on the patient and consequently it should be granted according to the guideline. Several restrictions were proposed during the seventies, but it took a full decade before this regulation succumbed to its own success.

As part of a general attempt to cut the costs of the health care system, a new regulation was adopted in 1980. Under this new regime, plastic surgery was still to be covered by the social health care system, but the patient had to contribute half of the costs herself up to a maximum ranging from 3000 guilders in 1980, to about 3800 in 1990, when the second regulation was replaced by the present one. The own contribution was not required if one of the following three criteria were met:

The treatment is meant:

1. to correct a physical deficiency falling outside the normal variation range for appearance;
2. to correct or remove a somatic functional disorder or complaint;
3. to prevent or alleviate considerable mental suffering.

(Ziekenfondsraad 1990: 7)

The Medical Insurance Board committee that prepared the new regulation, was well aware that “the normal variation range” was a vague criterion, likely to give rise to borderline disputes. The question arose whether it was too vague to be workable. A panel of experts was asked to examine if a limitative list of treatments and operations should be included in the regulation as a complement to the general criteria in which it was stated. According to the experts, the criterion was precise enough, and a limitative list was not called for. Unfortunately, the reasons for neither of these opinions were published in the commission’s report. (Ziekenfondsraad 1979: 41-47) Instead, a special committee was installed, the National Evaluation Committee, that was to adjudicate cases in which the patient felt she had been unjustly refused full compensation.

So much for the normal variation range. The criterion concerning mental suffering was accompanied by a letter in which some indications were given as to how that criterion should be applied. Instead of mental suffering that was considered to be too subjective, the letter referred to psychiatric disorders that supposedly were more objective. Among other things, the doctor or psychiatrist should check whether the patient suffers from some kind of psychiatric disorder (phobia, neurosis, psychosis, depression) and if so, to what degree the disorder is manifest. (Ziekenfondsraad 1990, Supplement 2)

The criterion concerning somatic functioning was not thought to give rise to any special difficulties.

This “own contribution regulation” as it came to be called, had two objectives: to cut costs and secure equal application of the criteria. Neither of them was realised. The amount of plastic surgical treatments kept rising and with them the costs kept rising as well; and there were misgivings about the equality of the application of the regulation across the different social health care funds. (Starmans, 1988: 25)

These two problems eventually led to the adoption of a third regulation, the one we have at present. The elimination of the own contribution and the removal of the normal variation range criterion together with its accompanying Committee, and a stricter formulation of the remaining

criteria are the most salient changes in the present regulation. Instead of three, it contains six criteria:

- a. deficiencies in the appearance that evidently cause physical dysfunctioning;
- b. mutilations caused by illness, accident or medical intervention;
- c. paralysed or sagging eyelids evidently causing a diminished range of vision;
- d. the following congenital deformations: lip-, jaw-, and palate clefts, deformations of the facial bones, bat ears, benignant growth of blood vessels, lymphatic vessels or interstitial tissue as well as birth-marks and deformations of the urinary passages and genital organs;
- e. the external genital organs in the case of acknowledged transsexuality;
- f. deformations in the appearance that cause such mental suffering that the patient is permanently seriously harmed in his psychic well-being and the correction of the deformation can reasonably be expected to remove the mental suffering. (Bruijn e.a.)

If you compare these criteria with the criteria in the “own contribution” regulation, the differences are not so great as they might seem at first glance. The first criterion, the physical dysfunctioning, corresponds to the functional disorder criterion from the older regulation; the last one is just a new version of the mental suffering criterion; c and e fall under either the functional or the mental suffering criterion. The remaining two, the acquired mutilations and the congenital deformations, can be seen as the offspring of the normal variation range criterion, the former consisting of the not enumerable afflictions, the latter of the enumerable ones. That leaves us with virtually the same criteria, except that the new ones are generally somewhat stricter formulated than the older ones and some limitative listing has appeared on the scene.

### ***Plastic surgery and private clinics***

European countries have different historical backgrounds with respect to the development of plastic and cosmetic surgery. While in some countries aesthetic surgery is seen as part of plastic surgery, this part is excluded in definitions of plastic surgery in other countries (Tan, 2000: 28). As a result of the different historical developments of plastic surgery in the European countries, consensus concerning a definition of plastic surgery was hard to obtain. The European Union of Medical Specialists (UEMS) agreed on formulating a definition in 1989, but only after a long and difficult process. Differences in historical development have also resulted in variable standards of training of plastic surgeons with respect to duration of the programme, requirements for trainees, trainers and training centres, the selection of trainees and the assessment. Although the European Council has issued some formal



requirements, such as a minimal training period of five years, these requirements did not include substantial educational standards. However, standardisation may be necessary to prevent them from practising without proper training. Tan therefore recommends standardising training requirements on a European level. He suggests that European organisations, such as the UEMS and EBROPAS (European Board of Plastic, Reconstructive and Aesthetic Surgery), and national organisations get together to harmonise the training in plastic surgery and to organise quality control.

According to Tan, the lack of adequate control and uniform requirements of the training of plastic surgeons on a European level may not be of great concern as long as migration does not take place on a large scale and as long as national organisations exert control. However, regardless of migration, countries should regulate the practice of plastic surgery adequately in order to prevent that citizens will be harmed. In the Netherlands, for example, visiting committees conduct quality controls of training clinics as well as non-training clinics. Relevant laws are the Act concerning the professions in health care (Wet BIG) and the Act primarily concerning patients' rights (WGBO). In addition to these two Acts, there is an Act concerning the quality of health care institutions (Kwaliteitswet Zorginstellingen). However, private clinics do not fall under this Act. Presently, they do not have to be registered nor do doctors need a permission to start a clinic in the Netherlands. As a result, the Dutch Inspectorate of Health Care does not know whether, where and how many private clinics exist. Since private clinics are in general not open about their practice, there is little insight in, and more important, hardly any quality control of private clinics. Due to this situation, it is impossible to give reliable statistics concerning the amount of plastic and cosmetic surgery. The Information Centre of Health Care in Utrecht (SIG) provides data of the number of hospital admittances. According to the SIG, 8765 men and 11762 women were admitted in day-nursing and 8998 men and 18508 women admitted in the clinic in 1994 (total: 48033). In 1999, 7729 men and 16935 women were admitted in the clinic, while in day-nursing 12496 men and 18392 women were admitted (total: 55552). As mentioned, these figures do not include the private clinics and therefore give no idea about the total amount of plastic and cosmetic surgery. The situation is no better in other European countries, with the possible exception of Germany. (Tan, 2000)

The lack of reliable data concerning the number of plastic and cosmetic surgery may also weaken the effectiveness of a register for breast implants nationally and on a European level. Since 1995, a registry was established in The Netherlands (DRIPS: Dutch Registry of Implants in Plastic Surgery) on initiative of the Dutch Society of Plastic and Reconstructive Surgery. DRIPS was installed after publications of possible negative side-effects of silicone implants in the USA. The aims of DRIPS are to provide information about the medical practice of plastic surgeons, to control the quality of breast implants, and to identify patients in case of medical necessities. Moreover, it has set up a database for scientific research and

for the quality programme of plastic surgery (e.g. for the visiting committees). The European Committee on Quality Assurance and Medical Devices in Plastic Surgery is also considering setting up a European register of breast implants. However, if private clinics do not co-operate these registers will not enable an adequate quality control of implants.

Most private clinics advertise in glossy magazines. The Royal Dutch Society of Medicine forbids advertisements by doctors. The Dutch Society for Plastic and Reconstructive Surgery takes a similar position regarding private clinics. However, these moral codes are not effective because they have no legal force. A similar situation prevails in other countries. The Senate of Surgery of Great Britain and Ireland has published guidelines for surgeons on ethical and legal issues (The Senate of Surgery of Great Britain and Ireland, 1997). Although surgeons are allowed to provide patients with information of surgical procedures, the guidelines state among others that advertisements should be truthful and factual. To reduce the risk of harm to the patient caused by advertising, surgeons should not accept a patient without referral of a general practitioner or other clinicians. In the same vein, the Code of Ethics for the International Society of Aesthetic Plastic Surgery states: “be aware of disciplinary action if: Patients are solicited by advertisement which contains misrepresentation, or is likely to deceive, or create false or unjustified expectations, or imply that skills are superior to other equally trained physicians; or advertisement that contains implications that would cause the lay person to misunderstand by primarily appealing to the fears or emotions of the lay person.” However ethically correct these guidelines may be, it is obvious that only the law can enforce a particular behaviour.

### ***Summary***

Purely aesthetic surgery is not covered by the social health care system of any country in the EU. Clear and definite as this statement may seem, it is unjust and unreasonable as it stands and not surprisingly, its edges are blurry and exceptions abound; just how to delimit them is a problem all European countries recognize. Several countries fall back on the same general guidelines. Appearance that falls outside some range of what is socially acceptable, that hamper the possibilities to get or hold down a job, that causes dysfunction or a concern over malignancy, are all frequently paid for (UK, Germany, Belgium, the Netherlands). It seems as if one single criterion underlies these others: suffering, often but not exclusively, caused by social norms.

As to the quality of the surgery, there are very few general guidelines, and private clinics can operate with no or little control. Which and how often operations are performed is nowhere registered, a fact that makes quality evaluations impossible.

## **PART II**

### **ETHICAL FRAMEWORK**

## 5 The meaning of physical beauty

*The idea that beauty is unimportant or a cultural construct is the real beauty myth. We have to understand beauty, or we will always be enslaved by it. (Etcoff, 1999: 242)*

Ever since human beings exist, they have beautified and adorned themselves. Historical and anthropological studies show us innumerable examples of people having scarred, pierced or painted their bodies. Whatever form they have chosen, painting and tattoos in so-called primitive cultures, colouring and dying of hair with henna, they all serve to distinguish people from one another. The pursuit of beauty seems to be universal.

More interesting than this statement, is the question whether our views and valuation of beauty have been the same through the ages. According to the historian Marwick, physical beauty is nowadays seen as a value in its own right. It can be defined in terms of the features of a person's body independent of other features such as a sense of humour or intelligence. Put differently, beauty is only skin-deep. The view that physical beauty is autonomous is a modern thought, rooted in the Enlightenment and positively valued since the 1960s. The classical idea of beauty however, is conflated with prejudices, taboos and religious and moral views, while attitudes to physical beauty were ambivalent at the least. Traditionally, beauty indicated sincerity and purity of heart, while ugliness was seen as a sign of unreliability. For example, in the 16<sup>th</sup> century Tagliacozzi, a professor of surgery at the University of Bologna, formulated a theory that face and character were connected: "the face is the mirror of the soul, its beauty or imperfections mirror the status of the soul." (Gilman, 1999: 70) At the same time, physical beauty was considered as dangerous due to its link with sexuality. In those days, true beauty was inner beauty.

Marwick also argues that physical beauty is a universal phenomenon. Throughout the ages, people have valued the same physical beauty. That is because beauty norms are universal. They are based on form and shape, proportion and harmony, symmetry and fit. These norms are not confined to one single standard of beauty, but allow for a wide variety of physical properties (black or white, blond and red, tall and short, blue and dark eyes etc.). All these different types may be evaluated as beautiful as long as they correspond to the beauty norms. Empirical studies show that there is a significant agreement across age, sex and culture about which people are considered to be beautiful. When subjects are asked to select the 10 most beautiful people from a group of 200, their choice shows a wide consensus. According to Marwick, this shows that beauty is not in the eye of the beholder, but in the eye of all beholders.

Etcoff defends a similar view in her book *The Survival of the Prettiest* (Etcoff, 1999). Etcoff describes beauty from an evolutionary-biological perspective. Physical beauty is a universal and biological characteristic. Our passion for physical beauty is rooted in our genes. We value physical beauty because it signals biological fitness. “We love to look at smooth skin, thick shiny hair, curved waists, and symmetrical bodies because in the course of evolution the people who noticed these signals and desired their possessors had more reproductive success. We are their descendents.” (Etcoff, 1999: 24)

Marwick and Etcoff both use a narrow definition of ‘beauty’: it refers primarily to bodily features. Moreover, they seem to evaluate beauty solely from a third-person, external perspective, a perspective that is unrelated to observer and context. (Hilhorst, 2001) We acknowledge the importance of physical beauty in this narrow sense. Physical beauty is an important human value. Many people strive for it and appreciate having a beautiful body. Physical beauty is becoming increasingly important in the social and economic spheres of modern life (Laermans, 1993:34). Many studies show that beautiful people earn more and have more success (Maassen van den Brink, 2000). Beauty is a valuable asset, especially in modern societies where social mobility seems to create the need to present oneself quickly. One should, however, not overrate the importance of beauty. Beautiful people are being treated and valued more positively, but this does not necessarily imply that beautiful people are happier. There exists no simple relationship between improving appearance and increasing happiness and quality of life (chapter seven). Belief in the beauty myths (beautiful people have happier lives, are more intelligent, and have better relationships) is persistent, but there is little or no scientific evidence to support it. In modern societies with omnipresent media images, these beauty myths may be hard to disentangle.

Although we acknowledge the value of a narrow definition of physical beauty, we argue that to fully understand the concept of physical beauty and our experiences with respect to beauty and appearance, we need to go one step further. We need a broader definition of physical beauty that is relative to context and person. This broader definition refers to a context that exceeds physical looks (body, face, figure); it also includes artistic appearance (clothes, make-up, perfume, hair); personal looks (impression, aura); performance (voice, attitude, behaviour); personality (charm, charisma, appeal, allure); relational capacities (contactual skills, communication competence); friendship abilities (reliable, nice, offbeat, loveable, companionable). As opposed to a narrow definition of physical beauty, this artistic beauty is not innate or given, but man-made. Artistic beauty, therefore, inevitably refers to current views on cosmetics, fashion and individual self-expression. It is “achieved by cultural means and expresses someone’s personal choice and intentions” (Hilhorst, 1998). If we are expressing our opinion on someone’s physical beauty with this broader definition in mind, we must admit that beauty norms are not as objective as Marwick and Etcoff appear to believe.

To judge *human* beauty we need more than a third-person perspective; we also have to use a first-person perspective (e.g. the reasons and motives of an individual for wanting a surgical intervention) in order to make beauty judgments. This may be illustrated by the example of an 80 year old woman who undergoes several cosmetic surgery treatments that make her look like a 40 year old woman. Some people would not consider her as beautiful, but rather feel pity and consider her appearance as distasteful. Beauty judgments are relative to a context, e.g. age. Although scars or a crooked nose are deviations from the formal norms of physical beauty, these deviations may belong to a specific individual; they may be considered as part of her physical beauty.

So, formal norms of beauty are not sufficient for judging human beauty. In order to evaluate someone's physical beauty, additional considerations of personal identity and cultural context should be taken into account as well. Aspects such as motives, feelings, interests and reasons are included in such a broad perspective. These aspects are taken into account while making beauty judgments about human beings and in particular while evaluating cosmetic surgery. Observers also assess the reasons an individual has for this intervention. Evaluating motives and reasons for changing appearance is characteristic of being human. What is at stake is that we want to understand other people's reasons, whether they 'fit' in their personal stories.

As we saw in chapter one, the stories people tell about their bodies are about how they experience a physical characteristic, how others react to it, how physical characteristic are integrated in their life and personal identity. The example of a boy missing a hand may be illustrative (Hilhorst). The boy and his parents may deal with this fact in different ways. They may try to conceal the missing hand as much as possible by choosing a 'natural', flesh-coloured prosthesis, or they can decide not to take a prosthesis and take the child 'as he/she is', or instead choose an artificial eye-catching device with bright colours. These choices express different views of conformity, adaptation and uniqueness. In order to evaluate their choice, we must take the background of the identity of the individuals involved and their social context into account. Stories in which context and contrast are expressed, provide the sense needed for a full understanding of the concept of human beauty.

### *Summary*

Beauty comes in two kinds. In a narrow sense, it can be defined in terms of a person's physical features independent of other characteristics. Physical beauty can be objectively evaluated, without referring to an observer or context. Whether someone is beautiful or not in this sense, depends on biologically anchored universal beauty norms, based on shape, proportion and harmony. There exists empirical evidence which shows a large amount of cross-cultural agreement on which persons are considered beautiful. Beauty in this narrow sense is an important human value in modern societies where self-presentation seems to be a condition for success in the social as well as the economic sphere.

Although we acknowledge the importance of physical beauty, a broader concept is needed to account for all our aesthetic experiences. Beauty in a broad sense is relative to context and personal identity; it refers to character, performance, and relational capacities. When we evaluate a particular cosmetic intervention, we tend to include the motives, reasons and interests of the person involved. Put differently, when making broad beauty judgments, one must take into account the personal histories and the cultural context.

## 6. Beauty and the freedom to choose your own lifestyle

### *Freedom or slavery: a dispute*

Considering the amount of time, money and effort some people spend on clothes, cosmetics and their looks in general, the pursuit of beauty is a lifestyle if anything is. One feminist aptly calls it 'a deeply significant existential project.' (Morgan, 1991: 36) We take an enormous interest in the looks of our body: we paint and pierce it, we keep it in shape through exercise and diet, and we take it to the cosmetic surgeon if we're really dissatisfied with some specific part of it. People do go to considerable lengths and are willing to incur serious risks, to change the appearance of their bodies for what they take to be the better.

Concern about their looks guides people's lives. So in one important sense the pursuit of beauty is clearly a lifestyle. But paradigmatically, in order to qualify as a lifestyle, a way of life should also be something you have chosen yourself. A lifestyle is a way of showing the world which things in life you deem important, what kind of life you want to live, what kind of person you want to be. This goes for men as well as for women. But the massive media pressure on women to live up to some ideal beauty-standard, makes it particularly doubtful whether women's choices concerning appearance are anything but mere reflections of fashion, or worse still, of male-dominated power relations. Can women's pursuit of youth and beauty, then, ever really qualify as a freely adopted lifestyle?

At least one feminist answers the last question with a resounding 'No!' In an article called: *Women and the Knife: Cosmetic surgery and the Colonization of Women's Bodies*, Kathryn Pauly Morgan suggests that women do not use the medical technology to underscore their uniqueness or eccentricity, rather they all let one and the same *Baywatch*-standard determine their looks. More often than not, what appear at first glance to be instances of choice turn out to be instances of conformity. There is an overwhelming pressure to undergo cosmetic surgery. The technological beauty imperative enforces itself in numerous ways: through advertising, articles in the media, in so-called success stories, and in Miss America pageants. At the same time, the beauty imperative sets a new norm; those who refuse to submit to it will become stigmatised. What used to be normal is rapidly becoming deviant, problematic, inadequate and deformed.

In her book, *Reshaping the Female Body*, Kathy Davis offers a totally different picture of cosmetic surgery and the partial freedom women enjoy to avail themselves of its mixed blessings. Davis has investigated the actual decision process of women contemplating to undergo cosmetic surgery. Typically, they take the step to consult a cosmetic surgeon only after having pondered the decision for years. Often they seek support from a woman who has had cosmetic surgery herself, rarely from a husband or lover. Usually they have to overcome opposition, from friends, family and



colleagues. All the women Davis talked with insisted that they wanted the surgery for themselves. Interestingly, even women with very bad side effects and permanent disfigurement were happy they had finally taken their lives in their own hands.

In the last chapter of her book, Davis takes issue with Morgan about the nature of cosmetic surgery and the freedom of choice. Davis does not deny that there is pressure on women to have their bodies altered, but throughout her book she stresses women's agency. Cosmetic surgery is not simply imposed, it is fervently desired by its recipients. Women having cosmetic surgery are knowledgeable and responsible agents, no 'more duped by the feminine beauty-system than women who do not see cosmetic surgery as a remedy to their problems with their appearance.' (Davis, 1995: 163) At the same time, she regrets the fact that women are willing to undergo risky operations. She wishes that circumstances would be otherwise and that women would choose a different course of action.

On the face of it, Davis' conclusions seem to be by far the more plausible. They are based on sound, empirical research, whereas Morgan has done little more by way of empirical investigation than skimming a few glossy magazines featuring interviews with knife-happy surgical dopes. But, alas, the controversy cannot be so easily settled in favour of Davis. It is not at all an easy job to decide how the data should be interpreted. Morgan could acknowledge all of Davis' results and yet stick to her own theory. Women may well *say* or *think* that they make their own choices, whereas *in fact* they are only doing what the system requires them to do. It is hard to see how this disagreement about the interpretation of the empirical data could be solved empirically.

Nor does more qualitatively oriented research provide any clear answers. The British Medical Association has surveyed the research on the influence of media on body-image. In the 1920s - 1930s the 'hypodermic account' was the dominant theory, an approach that claimed that media manipulated and exploited individuals. In the 1940s - 1960s research indicated that the audience actively selected and filtered the presented information. Recent studies stress the indirect role of media on behaviour; particularly the body perception of persons who have low self-esteem is influenced. For example, in many of the case histories of eating disorders and in the description of trigger causes for the onset of the disease, low self-esteem would appear to be a prevalent psychological precursor to the development of eating disorder. The media may contribute to low self-esteem in young women by promoting the myth that slenderness is the path to social, sexual and occupational success. (See chapter seven)

In a study of 94 adolescent women reporting what television programmes they had watched in the previous week, it was found that the amount of television watched did not correlate with body dissatisfaction and drive for thinness, but category of programme was significant. Body dissatisfaction was significantly positively correlated with watching soap operas or serials, and movies. Drive for thinness was correlated with time spent watching music videos. Body satisfaction increased with watching sports. It is difficult, however, to establish any causality between types of

television programme watched and body satisfaction, as young people who are dissatisfied with their bodies may seek out particular kinds of television viewing.

There seems to be a fairly general agreement that the daily exposure to appearance related articles in newspapers, magazines and on television, must somehow contribute to feelings of insecurity and self-doubt about acceptable body image, but the effects of the media are diffused in society, to the extent that it is difficult to single out particular examples of it directly influencing behaviour.

### ***Freedom within reason***

Underlying the empirical disagreement and uncertainties is a conceptual problem about freedom and responsibility. Neither Morgan nor Davis makes it very clear how the beauty-system actually sustains its coercive influence. Morgan has not made any empirical investigations into the matter, but she makes two suggestions. In the first place, its evil influence is spread by men, 'brothers, fathers, male lovers, male engineering students who taunt and harass their female counterparts, and by male cosmetic surgeons.' And if not by actual men, then by 'hypothetical men' who live 'ghostly but powerful lives in the reflective awareness of women.' (Morgan, 1991: 36)

Davis, who has painstakingly investigated women's actual decision-process, concludes that contrary to what is assumed by Morgan and many others, women are not pressed into the operation by actual men. As a matter of fact, husbands and boyfriends more often than not tried to talk their partners out of it. For that reason, some women even concealed that they were planning to have an operation from their husbands or boyfriends. Actually, when Davis describes what makes women try cosmetic surgery as a last resort, other women figure prominently not only as support, but also as catalysts. Many of the painful remarks about their appearance were made by other women, either out of jealousy, or condescension or mere thoughtlessness.

However, Davis does think a considerable pressure is being exerted by something much more abstract and far less tangible than real men or women, something she calls 'the beauty-system' or 'the gender society', and sometimes still less specific 'the social order', without elaborating on its content or working. But according to Davis this pressure is not so strong as to actually coerce women into cosmetic surgery. They are left with a choice. Her formula for this ambiguous situation is: choice, constrained by circumstances, which are not of the agent's own making. The constraints she refers to are the relative lack of information about the operation and its possible consequences and secondly, the lack of viable alternatives for women in a society organised by gender and power hierarchies.

Lack of information is something that is inherent in all choice-situations. People do not have perfect foresight: some options are apt to be overlooked, and the ones considered could always turn out to be different from what was being imagined. Notoriously this holds for medical interventions. But only if the surgeon withholds available and relevant information on purpose could the situation

be called coercive. In that case, women would be forced to make a decision on a skewed set of data. If this actually happens, they cannot make a free decision and therefore they cannot be held responsible for it. But this is hardly a controversial case. Literally everybody agrees that the surgeon should give her all the relevant data. If he does not, he is to be blamed, not she.

The complaint about lack of viable options is much more difficult to deal with. What options are lacking, what circumstances should be different? We have no faithful figures, and they would be very hard to come by, but the number of women that does opt for cosmetic surgery is almost negligible compared to the number that does not. In order to make the claim that women have no viable options except cosmetic surgery at all plausible, the category of women it applies to has to be made much more precise. Suppose such a category could be defined: women with characteristics a, b and c all opt for cosmetic surgery under circumstances x, y and z. Even if this claim could be vindicated, nothing as yet would have been established as to what actually causes them to do so. Physical and psychological characteristics like size of breasts and lack of self-esteem would presumably figure on the one side, and stereotypes and role-models are among the things that would figure on the other side of some such explanation.

Suppose then that the statistically significant correlation could be dressed up to a causal explanation for this well-defined category of women, would that make them into the unfree and irresponsible zombies Morgan takes them to be? Not necessarily. Being caused to do something is not in itself a threat to either freedom or responsibility. It would only be so if you hold that free and responsible agency implies the ability to act in defiance of the causal network that makes up the rest of the world. It is a wildly implausible claim that people have such a contracausal metaphysical power. If you were to trace the antecedents of any act far enough, you would always find that its causes lie outside the agent. Usually acts are considered to flow from some combination of beliefs and desires. But of course one can always push the inquiry one step further back and ask where these beliefs and desires come from. Ultimately, they will be caused by something the person is not in control of. If being the ultimate cause of one's actions were a necessary condition for agency, nobody would ever be an agent.

According to a metaphysically less extraordinary view, agency is compatible with people being subject to all the laws that govern the rest of nature. Normally, what we will actually do and when we will do it, is the outcome of our deliberation. Our beliefs, values and attitudes make a difference. As long as our acts are sensible responses to the requirements of the situation, as long as we are able to respond adequately to all its relevant features, we have all the freedom we can possibly wish. If these relevant features leave me no option but a right one, that is no more a serious constraint on my freedom than the analogous constraint on belief formation would be. Our freedom would not be diminished if we were always caused to have only true beliefs.

The way Davis describes the women who take recourse to cosmetic surgery, fits this picture very well. These women have a problem — an indisputable kind of suffering — they survey their options, and they pick that option that promises them the best chances to overcome their problem.

They respond sensibly to the situation, make an intelligible decision and act accordingly. In particular, they don't expect the operation to work miracles; for instance that it will save a broken marriage. Admittedly, it is a somewhat risky option, but not an outrageous risky one. It seems therefore, that their decisions are based on a prudent cost-benefit analysis. What reasons could there be to call even this particular category of women innocent zombies and their decisions unfree or coerced? They do indeed seem to have all the characteristics of knowledgeable and responsible agents.

It might be countered that even if the 'gender society' leaves women's capacity to reason instrumentally unimpaired, it distorts their capacity to form values to act on. In that case, they would be duped by magazines, advertisements and all the rest into putting beauty and appearance at the top of their preference-ordering. They would value beauty more than they should, spend more time and money on cosmetics than is proper and accord too little weight to other important things in life. To put it briefly, they would have become obsessed by their appearance, and obsession does not sit well with free agency.

But who can tell what the proper amount of attention is to pay to your appearance? Is lipstick OK? Going to the hairdresser? Being choosy about the clothes you wear? Dieting? Fitness? Twice a week? Two hours a day? Everybody can come up with extreme examples of paying either too much or too little attention to appearance, but in-between all cases are hard cases. All lifestyles can give rise to misgivings. Who can ever be sure she is not according too much importance in life to something not really worth it? How can you know that you would not be happier or lead a more satisfying life if you had chosen something completely different? To take up a lifestyle is to forsake other, equally choiceworthy ones. That is one of the reasons Morgan's description of the pursuit of beauty is such an appropriate definition of a lifestyle in general: it is 'a deeply significant existential project,' with all the meaningfulness and uncertainty that usually go with such projects.

Still, probably some people are not persuaded that women have a sufficiently free choice in these matters. Given the circumstances such as they are, women are free to choose whether they want to take their recourse to cosmetic surgery or not. To be free in a practical sense does not mean to be the uninfluenced originator of all your thoughts and actions; whoever fits that description is doomed to act in a haphazard and unintelligible way. Rather, it means to be able to respond adequately to the circumstances in which you find yourself. We want 'a freedom *within* the world, not a freedom *from* it', in Susan Wolf's apt phrase. (Wolf, 1991: 93)

But sometimes we want the world to be different, rather than just to be able to respond adequately to the way it happens to be. Different cultural ideals for women (and men) come and go like fashion; slim in the twenties, buxom in the fifties. In a sense you could say they are man-made, albeit not in any direct or simple way. They would be very hard to influence for individuals, but perhaps governments or non-governmental organisations should do their utmost to change them. Or rather, to get rid of them altogether. Changing them, after all, would only change the category of women that could not live up to them and hence would

suffer from their falling short of these ideals. If that is too much to ask for, at least it could be attempted to soften up the ideal by promoting diversity. A very good example of what can be done, is a Body Shop campaign featuring an ad with a not so slender woman and the text: There are 3 billion women who don't look like supermodels and only 8 who do.

### *Summary*

Given the fact that norms of appearance are social, can the decision to have plastic surgery ever be anything but a mere reflection of the prevailing social norms? There is a fierce debate among feminists and others about the influence of the media and society in large on decisions of women to undergo cosmetic surgery. Are those decisions imposed, or are they made autonomously? This is a question that has mainly been dealt with empirically, but a significant part of it is philosophical. Before freedom can be investigated empirically, you have to know what it is that makes a choice a free choice. We argue that what matters is not whether an agent was influenced by factors beyond her control or not, but whether she was able to respond adequately to the circumstances in which she finds herself. Arguably, circumstances may become so oppressive, that no adequate choice is left and hence no freedom of choice either. To forestall such situations, governments and non-governmental institutions should promote a diverse range of beauty ideals.

## 7 Medical necessity: the normal and the natural

As described in chapter three the history of plastic and cosmetic surgery shows an ambivalent attitude among the general public as well as among plastic surgeons. Surgery for patients with severe congenital malformations or gross disfigurement after burn accidents seems to be valued as a positive and useful practice. Such medical interventions are characterised as medically necessary, whereas cosmetic interventions are considered to be as luxury and even vanity. Cosmetic surgery is therefore thought of as falling outside the medical realm and the scope of publicly funded medicine. Although attitudes to plastic and cosmetic surgery have been changed to a more positive view, ideas about proper and improper uses of plastic surgery can still be found. These ideas may be based on two sorts of distinctions: 1. the distinction between disease and non-disease, and 2. the distinction between treatment and enhancement. In both distinctions notions of ‘normal’ and ‘natural’ play an important role. In the following we will analyse these distinctions and see whether they can function as criteria to decide which interventions do and do not belong to the medical realm and should be covered by health insurance.

### *Disease versus non-disease*

When people argue that some interventions are medically necessary whereas others clearly are not, they may refer to the argument that medicine is meant to treat diseases and that no non-diseases belong to the medical realm and hence that doctors should abstain from dealing with such cases. However, this distinction raises several serious problems. First, doctors are already involved in treating conditions that can hardly be defined as diseases, as is the case with treating infertility problems (e.g. artificial insemination, In Vitro Fertilisation) and abortion on demand. A proponent of this non-disease argument could reply that only doctors have the medical expertise and that this is the reason they should also be allowed to perform these kinds of interventions. This response implies that all kinds of non-disease related medical interventions would be allowed merely because doctors possess specific expertise.

Another response to the charge that medicine is already involved in treating non-diseases could be to accept the charge and subsequently to exclude these kind of non-disease related interventions from the medical realm. But this hard-core version of the non-disease argument is also problematic: it requires a clear distinction between disease and non-disease and therefore an understanding of the disease concept. It is highly questionable whether a neutral and specific disease concept can be formulated. One attempt is Boorse’s biostatistical theory.

He claims to have formulated a value-free theoretical definition of health: “Health is normal functioning, where the normality is statistical and the functions biological.” A function, in Boorse’s view, is a contribution to a goal. Eventually, the goals are individual survival and reproduction. The goals of an organism can be determined by averaging a large sample of that kind of organism (differentiated to age and gender). On the basis of this study a species design can be discerned. This species design, then, serves as the basis for health judgements: the physician can establish whether someone is healthy by determining whether the functioning of the body matches with the design of the species. One result of Boorse’s concept of normal functioning ability, is that some phenomena would be categorised as healthy or normal while the medical literature defines them as diseases that can and should be prevented, e.g. arteriosclerosis or dental caries. To meet this objection, Boorse therefore extends his definition of disease: “a disease is a type of internal state that is a limitation on functional ability caused by environmental agents”. The extended definition and these examples, however, illustrate that a cultural context must be included in order to determine what is normal. In order to determine what normal or good functioning means, information is needed about the circumstances in which functioning takes place. A biostatistical concept will not do, because biology gives us too little guidance of what is normal or abnormal.

### ***Treatment versus enhancement***

The second distinction that might help to decide which interventions are proper or improper uses of plastic surgery is the treatment-enhancement distinction. This distinction permits doctors to treat patients but prevent them from enhancing people’s characteristics in order to make them more beautiful, athletic or intelligent. Someone who argues along the lines of this distinction should be able to explain the difference between enhancement and treatment. We already discussed the weak sides of the disease-argument, so a proponent of the treatment-enhancement distinction cannot appeal to this argument. A difference between treatment and enhancement could be caught in terms of temporal difference. An intervention, then, is characterised as a treatment if it restores a previous appearance. For example, a breast restoration for a woman whose breasts are amputated due to breast cancer could be labelled as a treatment. But breast augmentation for women with small breasts would be characterised as an enhancement. Strangely enough, an augmentation would fall in the same category as medical interventions to correct congenital malformation: both procedures would definitely be labelled as enhancements.

The treatment-enhancement distinction leads to another odd conclusion as well. All kind of changes in appearance caused by ageing would be categorised as restorative and interventions to stop symptoms of ageing would therefore be labelled as proper uses of plastic surgery. One might argue that it is obvious that these kinds of interventions should be

excluded since they are natural biological processes. Critics of cosmetic surgery use the term 'natural' to argue that one should accept bodily characteristics or natural changes of one's body. Ageing (becoming bald and wrinkly) is a natural process people should accept; some even argue there is a duty to be natural. However, this solution is hard to defend because natural processes are not equivalent to an ethically acceptable practice. Additional arguments are needed to determine whether one should intervene in natural processes or not.

So another interpretation of the treatment-enhancement distinction is called for if it is to function as an adequate criterion to select proper and improper uses of plastic surgery. Maybe a definition of enhancement formulated in terms of normality might help. This definition could be formulated as: "The results of an intervention constitutes an enhancement if: 1. The function or state of the patient is above normal after the intervention, and 2. The function or state of the patient was not above normal before the intervention." (Holm, 2000) As soon as one reads this definition, it is obvious that an additional definition is needed, namely of normality. And that is exactly where problems arise. We could, for example, interpret normality in a statistical sense, but in that case the results depend of the choice of the reference group: what is statistically normal in one (affluent) country is not normal in another (poor) country. It is practically impossible to choose a reference group in a neutral way. A statistically interpretation of normality will therefore not be very helpful. As an alternative we could interpret normality in terms of social normality. Unfortunately, such an interpretation also raises problems, since there are no universal guidelines, which are specific enough to make a distinction between treatment and enhancement. Such norms will differ among cultures and times. Proponents of the treatment-enhancement distinction in terms of social normality therefore have to contend with the question whether social norms are justifiable.

As the personal stories in chapter one and the cases in chapter two showed, people who choose medical interventions to change appearances motivate their choice by appealing to a normal look, or a less abnormal one. Davis' interviews with women choosing cosmetic breast surgery show that these women desire to become ordinary and to be treated as such. They want to feel at ease with their body. A normal appearance may also be one of the reasons for medical interventions to change the appearance of children with Down syndrome. Apart from interventions to improve speech or breathing (e.g. reducing the tongue volume), such interventions may be done to make the appearance of the child more normal. Another example is the use of growth hormone for children with short stature (whether or not a disease has been identified). Suffering may result of having an appearance that deviates from a social norm.

To prevent or to mitigate suffering, one could choose several options: to change the norm, to change the appearance, or by changing the desire to conform to a social norm. Some argue that changing the appearance will lead to a reinforcement of the restrictive social norm. Changing the appearance of people with bat ears, short stature or Down syndrome, will result



in a much worse situation for those with abnormal appearances. It will reduce respect for and solidarity with people with abnormal appearances and eventually it will provoke stigmatisation and discrimination. Moreover, it could lead to medicalisation (the process in which more and more phenomena in human life are governed by a medical perspective). A side effect of medicalisation is that it turns healthy individuals into patients.

In view of these negative consequences, it seems we have to choose one of the other options: to change the desire to conform to a social norm or to change the social norm itself. An individual's desire to change his or her appearance in accordance with a specific social norm may result from identification with a norm or the belief that conforming to the norm will be socially or economically advantageous. Interference with the desire for a medical intervention is hard to justify, if such interventions do not cause serious harm to other people. The principle of autonomy demands respect for choices of individuals. Changing the social norm is not without problems either: social norms are hard to change and in the meantime the individuals involved may still suffer. So, changing the norm may only be an adequate option if success is guaranteed in the short run. An objection to this contra-argument is that it accepts restrictive social norms simply because they are difficult to change. Moreover it turns a collective problem into an individual one: our societies' (in)ability to respect human diversity in appearance is no longer the issue but the question whether individuals' wishes to change appearance should be respected.

In our opinion both distinctions, disease versus non-disease and treatment versus enhancement, are attended with serious problems. They cannot be used to guide us in questions regarding the proper uses of medicine and whether treatments should be covered by a public health care insurance system.

### ***Summary***

In this chapter we have analysed two criteria that might be used as criteria to decide which interventions belong to the medical realm, and furthermore, whether they should be publicly funded. These two criteria are grounded in the distinction between diseases and non-diseases on the one hand, and the distinction between treatment and enhancement on the other. Both distinctions are fraught with problems. It seems impossible to offer a neutral and specific concept of disease and a clear explanation of the difference between treatment and enhancement, be it in terms of temporal difference or in terms of natural processes or normality, is theoretically and practically unfeasible.

## 8 Appearance and the goal of a social health care system

One of medicine's primary tasks is the relief of suffering; to enable the patient to cope with his particular affliction or disorder. In so far, therefore, as cosmetic surgery can bring about such a relief, it belongs within any publicly funded health care system. It is not likely that it will achieve this goal in all cases. For some, the promises of cosmetic surgery are the start of a lifelong quest for perfection: they are willing to undergo any number of surgical procedures to fine-tune their new face. Unfortunately, they may become so obsessed with this that they fail to make any meaningful effort to rebuild their lives. Their surgical repair supersedes their social rehabilitation and makes that transition impossibly difficult.

At the other extreme from these 'perfectionists' are those disfigured people who seem almost to revel in their tarnished looks and show reluctance to go through surgical reconstruction. They use their disfigurement as an excuse for other social failings such as their inability to get a job. They may become very embittered about the treatment given to disfigured people and determined not to 'give in' by improving their facial looks. For this sort of person, the crusade is not for their own facial renovation but rather for a change in social attitudes to the disfigured in particular and the handicapped in general. One can find impressive examples of both in the first part of a book called *Visibly different. Coping with disfigurement*.

Cosmetic surgery is not something that you will undergo in isolation from the rest of humanity: disfigurement is, above all, a social handicap, and your course of surgery to try to diminish it must at least partially respect the wishes of the wider society in which you will circulate. This may suggest that you have to fulfil certain minimum social standards when deciding on how much plastic surgery to receive — and those are not easily discovered. Once you have satisfied the minimum standards, should you then continue to seek improvements? You have to compare the benefits of further facial advances with the costs on your time and lifestyle of doing so, and then make that judgement for yourself. Such a comparison can be successfully conducted only with the help and advice of the professional staff responsible for your treatment.

Plastic surgery comes in kinds. Treatments that are meant to restore physical dysfunctioning belong to the same category as treatments for say broken legs and worn out hips. Of course those costs should be covered by any public system. This part of the plastic surgeon's work is just a special kind of reconstructive surgery. Indeed, some of these operations are performed by other medical specialists as well, dermatologists and ophthalmologists for instance. It might not be the kind of work that the general public associates with plastic surgery, but it is its main part.

What the general public does associate with plastic surgery are face-lifts, tummy tucks and breast augmentations: superfluous and risky operations on women with too much money and time to spare. If they are decently done and the client is well informed about alternatives and risks, these operations belong to the domain in which people should have the freedom to do with their lives and bodies as they please. But, so the argument goes, they should no more be collectively paid for than other private aesthetic consumption, such as having one's house decorated or buying seductive perfumes.

It looks, then, as if the part of plastic surgery that should definitively be publicly funded is not really cosmetic surgery, and that the part that is cosmetic surgery proper should never be publicly funded. But why? In our opinion, suffering, suitably generalised and properly understood, covers all the cases in which functional as well as cosmetic treatments, such as treatments for bat ears, but also face lifts, tummy tucks and breast augmentations, should be remedied by public means.

There is no reason to operate a dysfunctional organ or structure that we do not now, and will not in the future, experience as distressing. If a deformation falling outside some socially determined norm is not the cause of any dysfunctioning, then why should treatment for it be covered? In itself, the mere fact that a deformation falls outside some statistically determined range provides no reason; there are plenty of such deformations that people can cope with and for which they do not seek any help at all. What really matters is the suffering such deformations might cause. If a deficiency is the cause of physical dysfunctioning — for instance impaired sight due to sagging eyelids or aching shoulders due to very large breasts — it will normally cause the person distress. We value sight and are handicapped in a hundred ways if we are not able to move and walk without pain.

Relief of suffering also seems to provide the best reason for cosmetic treatments: not everyone with bat ears is operated upon, only those that suffer from them one way or another are. And the size and particular angle with which ears stick out, their statistical properties, are only two factors determining the amount of suffering they cause, just as the size of breasts is only one factor for women seeking a breast augmentation. It is very well conceivable that of two people with exactly the same type of ears or the same size of breasts, both falling outside a given social norm, the one suffers from the deformation, whereas the other experiences no problem at all. What really matters is how an individual with his or her own more or less deviant appearance and psychological make-up manages to live with the norm for what is an acceptable appearance.

Given that relief of suffering is a fundamental goal of medicine, is it not too subjective in the case of appearance? That remains to be seen; after all, nothing seems more familiar to us than our — subjective — experiences. Before we start panicking about subjective criteria such as suffering, we are, therefore, well-advised to examine the reasons we have for disqualifying them as criteria in medical settings.

What does it actually mean to say that something is subjective, or too subjective? A correct, but otherwise not very instructive answer would be dependent on a subject, which could be further

explicated as dependent on experiences or mental states. But obviously, this ontological interpretation is not intended when a criterion is being disqualified because of its subjectivity. It is presumably not the existence of experiences that is doubted, but rather the possibility for third parties to know anything about them. A second, more relevant answer fastens upon this epistemic interpretation. As a point of departure, then, subjective experiences could be described as in some way connected to a particular experiential point of view.

Generally speaking opinions differ about how accessible such a point of view is. Is it entirely transparent to the subject self and utterly inaccessible to everybody else? If both these questions were answered in the affirmative, it would follow that there could be no standards of correctness to check any judgements pertaining to a particular subject's experience made by that subject himself. Public criteria that have the properties of first person transparency and third person inaccessibility would make us hostages of blind trust. One possible way to deal with criteria that are subjective in this strong sense, therefore, would be to attempt to replace them or convert them into more objective ones. On this view, the only way to prevent a sliding down the slippery slope that threatens once suffering is introduced as a criterion, would be to interpret it in terms of medical necessity. A second possibility to deal with experiential criteria would be to accept that they are of paramount importance for how someone's life is going. Since each person is the final authority on his own experiences and, moreover, third parties are in no position to criticise them, the only sensible conclusion must be that subjects should be granted an absolute right to decide in all matters that concerns only themselves.

However, the view of the subjective underlying both of these responses is unacceptable, and hence we should not accept any of these responses either: neither the false comfort of medical necessity (See chapter six), nor the desperate retreat to the inner citadel of autonomy. It is possible to know a great deal about other people's experiences and in medical settings it is important to make use of this possibility. Sometimes others are in a better position to know what we want and what is the best way to achieve it; our own motives are not always transparent to ourselves.

We have at least two reasons to care about the correctness of our introspection. If we want to avoid self-deception, if we want that what we actually do is what we think we do, if, in short, we want to be responsible and knowledgeable agents, we should do what we can to establish what the reasons for our acts really are. Considering the limits of both a first and a third person perspective, a dialogue may be the best way to achieve this. Secondly, it is important to know our reasons for wanting to have cosmetic surgery, because it may be the case that it is not the most adequate solution to the problem for which we take it to be the best solution. Sometimes, as in the case of patients with bodydysmorphic disorder, this is obvious; but in other, more ordinary cases, a dialogue with a sympathetic and experienced expert may correct unrealistic expectations and forestall harms and expensive disappointment. As motives are often obscure, alternatives unknown and decisions complicated, it is advisable for people who contemplate having cosmetic surgery to talk their decision over with an expert.

This is especially important if the alleged reason for enhancing one's appearance surgically is based on a presumed link between beauty and happiness.

### *Appearance and Happiness*

Research in the area of disfigurement consistently illustrates that there is no simple equation linking appearance and happiness. Adjustment in visibly different people is not predicted by the severity, extent, type or location of the disfigurement. Minor marks can have devastating psychosocial consequences, yet many people with extensive disfiguration are well adjusted. Recent work has highlighted the role played in social relationships by self-esteem, social skills, perceptions of social support, an optimistic attributional style and the variety of coping techniques a person has at his disposal. In addition, the personal accounts of many people with visible differences allude to the positive and growth-enhancing aspects of living with a disfigurement.

Many people maintain that 'beauty opens doors'. Certainly, being physically attractive may help you to meet people, but what kind of people are they? The chances are that the doors that are being opened are doors to glass houses. The people beyond the doors are those who judge others by appearances, and thus are likely to have only very limited understanding of factors contributing to successful long-term relationships. In addition, others often regard beautiful people with resentment, mistrust and envy. Many lack inner confidence — they have low feelings of self-worth as they feel that others want to be with them only because of their looks. They are plagued by 'what ifs' — what will happen when their looks fail? What qualities will they fall back on? There are high breakdown rates among the ranks of the superstars — with numerous reports of the famous suffering 'breakdowns', and checking into clinics in order to find themselves.

It is certainly the case that looks count in the initial stages of impression formation, but so do a host of other factors, including social skills and other aspects of self-presentation. Research on the mechanisms involved in forming impressions of people with disfigurement has shown that more positive impressions are formed of disfigured people who have high levels of social skill, than of non-disfigured people who are socially adept.

Attractive people may come to rely heavily on their looks, and in the process may fail to develop other important relationship skills. Research in social psychology tells us that successful long-term relationships are built on similarity of attitudes, beliefs and values. Beauty may be linked to social ease (beautiful people may have more practice in superficial encounters); however, it is not linked either to self-esteem or to longer-term happiness. So there seems to be little evidence to support the beauty myths.

Suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person. And as the person has many different aspects, her personhood can be

threatened in many different ways. Whatever else she may be, a person is a historically embodied social being. In a person's appearance, these three aspects — bodily, social and historic — coincide, and consequently, appearance can pose a threat to the intactness of the person. And by changing the appearance cosmetic surgery can sometimes ward off this threat.

Even if the meaning of 'suffering' were given in an adequate way, would suffering not be too normative or too generous or too arbitrary to serve as a workable criterion for a public health care? These are three complaints on three very different levels, and they must be dealt with accordingly. Just as every other criterion, suffering obviously is normative: the very sense of a criterion is to function as a guideline for acting, in this case for granting claims on treatments. Any criterion is normative by definition, so this cannot be a serious complaint.

Is it not too generous? Every practicable criterion has to draw a bottom line below which claims are not granted, and one of the most important determining factors as to where that line will be drawn is financial. The amount of suffering that a person is considered to be able to cope with, depends on the costs of alleviating suffering in general, all suffering that is, and with the costs for securing other basic goods necessary for leading a satisfying life as a citizen. Suffering will only amount to harm if it is unjust; the alleviation of all suffering cannot be paid for collectively, but in a reasonable just society some must be paid for.

Is it not too arbitrary? On the contrary, it is a great advantage that this criterion is not bound up with a fixed weight, width or length. A criterion does not get less arbitrary by fixing very precise and measurable conditions for its fulfilment, if those conditions themselves are arbitrary or inadequate. Suffering is an experiential criterion that cannot be domesticated into an unambiguous, objective one without distorting or even nullifying it. What matters is not whether the nipples are level with the recipient's elbows (Davis, 1995: 35) or the particular bat ear angle exceeds 43.5 degrees, but rather whether ears or breasts or whatever cause suffering or not.

### ***Evaluation Committees***

One reasonable way to establish whether someone is suffering in the sense of the regulation, would be to install some kind of an Evaluation Committee for advise on controversial cases. As we already saw in some of the case studies, it is not always clear why someone opts for a certain surgical intervention, not even for that person herself. To forestall disappointments and expensive miscalculations, it is advisable to discuss the wish with a professional consultant before going ahead with the surgery. It cannot be excluded beforehand that the desire stems from the massive and deceptive advertisements for all kinds of treatments that is published in all women's weeklies.

But there is another reason to do this as well. Public health care is a social good, and like all social goods it is vulnerable to abuse by free-riders. Wherever a social good is created, there has to be some kind of control on the claimants, and a committee is one way, and not an unreasonable one, to exercise that control.

But could such a committee work in an effective way if it were allowed to base its judgements on one criterion only? Even if its judgements would not necessarily be arbitrary, they would take far too long and hence be too costly to be feasible. Expediency is an important property of any system of rights, and a system based on just one rather abstract criterion would surely lack that property.

One way to safeguard expediency, therefore, would be to have a list of 'settled' treatments accompanying the regulation, somewhat like the standard jurisprudence in legal textbooks that explains the statutes it accompanies. In fact, such a list is presently being used in the Netherlands for just that purpose, the so-called black, grey and white list. Treatments that are never collectively paid for are on the black list, treatments always paid for are on the white, and the grey list contains the treatments that are sometimes paid for and sometimes not. This list does not have the legal status jurisprudence has; it is a working agreement between insurance companies and the Dutch Plastic Surgeon's Association that apparently works out rather well in practice (Wijthoff, personal communication). It has a default character: if weighty considerations turn up in a particular case in favour of compensation, even blacklisted treatments might be paid for.

### ***Summary***

The rules for including plastic surgical operations in a social or national health care system in the different European countries - dysfunctioning, discrepancy with prevailing social norms for appearance, incapacity to get or hold down a job, and suffering, can all be summed up in the last one, suffering, either on biological/medical grounds, or, more particularly, on social grounds. Disfigurement is a social handicap that can cause considerable suffering. Whether plastic surgery or psychological coaching or a combination of both is the best approach to relieve this suffering, should not be left to the patient to decide.

Since social norms are public, they are not subjective in the sense that they are arbitrary or too personal to base a regulation on. At the same time, it must be accepted that they are not very precise either. In cases where a decision not to pay for a certain treatment is disputed, therefore, a committee of experts could be installed for adjudication. To make the committee's job at all feasible, its members should have recourse to a default list of treatments that are always, sometimes or never paid for; such a list seems to work well in practice.

**PART III**  
**CONCLUSIONS AND RECOMMENDATIONS**



## 9 Conclusions

In the following we draw conclusions from our ethical analysis and evaluation in part one and two. Each theme in the conclusions corresponds with one of the chapters. We start with the conclusions drawn from chapter two that contains a selection of examples of the ethical issues with respect to changing appearances in health care. Conclusions regarding the value and meaning of beauty refer to chapter three and five, European rules and regulations to chapter four, the principle of autonomy to chapter six, the proper goals of medicine to chapter seven, and finally the concept of justice to chapter eight.

### *Ethical issues in health care with regard to appearance (Chapter 2)*

Appearance in health care, raises a diversity of ethical questions. The most important general ethical issues concerning changing appearance in health care that should be dealt with, are:

- the value and meaning of beauty
- the meaning and range of the principle of autonomy
- the proper goals of medicine
- the issue of publicly funded medicine.

### *The value and meaning of beauty (Chapters 3, 5)*

- Beauty is an important value in social as well as in economic spheres of modern life. A simple relationship between appearance and happiness, however, does not exist. Psychological characteristics such as self-esteem, social skills, perceptions of social support, an optimistic attributional style and a variety of coping techniques are crucial for having a satisfying life.
- Physical beauty is a broad concept, which is relative to context and person.
- Attitudes to plastic and cosmetic surgery have changed drastically within one century. Instead of being looked upon as a criminal and dubious practice, nowadays plastic and cosmetic surgery are valued positively. To explain these changes, one has to place the rise of plastic surgery in a medical as well as a cultural context.
- The general public still takes plastic surgery to be synonymous with cosmetic surgery, probably because cosmetic clinics advertise frequently.

#### ***Rules and regulations in Europe (Chapter 4)***

- Reconstructive plastic surgery is collectively funded in all countries in the EU, but purely cosmetic surgery is not. But this rule has two exceptions. Interventions meant to change appearance that causes suffering or lessens the chance of getting employed are sometimes financed publicly.
- Agreement on a definition of plastic surgery on a European level was hard to reach due to the different historical developments of plastic surgery in the European countries.
- Differences in historical development of plastic surgery have also resulted in variable standards of training of plastic surgeons. Standardisation is needed to guarantee a minimal standard.
- There are hardly any regulations concerning private clinics, neither on a national nor on a European level. As a result, there is little insight in, and more important, almost no quality control of, private clinics. Moreover, it is impossible to give reliable figures concerning the amount of plastic and cosmetic surgery and the number of private clinics.
- The lack of insight might also weaken the effectiveness of a register for breast implants. The aims of such a register are to provide information about the medical practice of plastic surgeons, to enable quality control of breast implants, and to identify patients in case of medical necessities. It can also be used as a database for scientific research and for the quality programme of plastic surgery (e.g. for the visiting committees). The European Committee on Quality Assurance and Medical Devices in Plastic Surgery is also considering setting up a European register for breast implants. If private clinics do not cooperate, an adequate quality control of implants will be seriously hampered.
- Existing guidelines for advertising within European countries are not effective because they have no legal force.
- Quality control of plastic surgery performed in private clinics and guidelines concerning advertising are hard to enforce.

#### ***The principle of respect for autonomy (Chapter 6)***

- Media exert considerable influence on (predominantly) women to live up to quite narrow beauty standards. But on a reasonable analysis of the ideas underlying genuine choice, the pressure cannot be considered to be so heavy as to annihilate women's autonomy and agency.
- It is often difficult to determine the motives for wanting to have cosmetic surgery, even for the patients and clients themselves. It is, in other words, difficult to make autonomous choices. The best way to find out about motives, expectations and alternatives, is to engage in a dialogue with a psychologist who has specialised in attitudes towards appearance and disfigurement.

- Our appearance is an important aspect of how we express ourselves; therefore, it is desirable that there is a broad range of acceptable options regarding appearance available for each to choose from according to taste and character.

### ***The proper goals of medicine (Chapter 7)***

- The general public views plastic reconstructive surgery as medically necessary, whereas surgery is thought of as falling outside the medical realm and the publicly funded medicine. This view is based on two distinctions: the distinction between disease and non-disease and the treatment-enhancement distinction. Both distinctions are attended with serious problems. Analysis of disease concepts show that they always contain a normative component. The treatment-enhancement distinction, defined either in terms of temporal difference or in terms of statistical or social normality, did not work either.
- Relief of suffering is a fundamental goal of medicine. Insofar as plastic surgery, either reconstructive or cosmetic, aims at this goal, it belongs squarely within the realm of medicine.
- In so far as appearance causes suffering it belongs in principle within the realm of medicine. Since the suffering stems from appearance and the way the patient or client is perceived by others, it is a socially caused suffering. A particularly appropriate name for plastic surgery therefore, is social surgery. Several authors have indeed suggested this terminology.

### ***The concept of justice (Chapter 8)***

- If plastic surgery treats serious social suffering, such treatments ought to be covered by any publicly funded health care system. The same holds if appearance makes it unreasonably difficult to lead a normal social life, for instance, if it worsens the position on the job market. Tattoo-removal would be an example.
- Since suffering is subjective and therefore not amenable to any precise regulation, one reasonable way to determine which interventions should be publicly paid for, is to install a committee with psychological and psychiatric expertise.

## 10 Recommendations

The following contains recommendations that are grounded in the ethical framework of appearance and health care. Our first recommendation concerns the need for additional philosophical and ethical research in order to develop justified policies on European and national levels. The next recommendation is fundamental and abstract in character: the criterion to determine what belongs to the medical realm and which medical interventions should be publicly funded. We have elaborated this important recommendation in concrete and tangible suggestions. Other recommendations concern more practical but not less important issues, respectively the quality control of plastic and cosmetic surgery especially in private clinics, a critical reflection of the role of the media, and the imitation of a successful organisation for individuals with disfigurements. The suggested policies and guidelines should contribute to a world in which we are moved by beauty without being enslaved by it.

### ***Philosophical and ethical research into the field of appearance and health care***

- Appearance has important consequences in terms of how we are judged and treated by others. It is to be expected that medical interventions to change appearances will be increasingly important in a individualistic consumer society. Philosophers and ethicists, as well as policymakers, however, have all but neglected this subject. This report is one of the few contributions to this issue. Further research is needed to deal with the fundamental philosophical and ethical questions raised by medical interventions to change appearances. Moreover, additional research is needed to keep up to new medical and genetic technologies and interventions, and to develop policies and strategies to prevent negative consequences for society as well as for individuals.

### ***Criterion to determine what belongs to a publicly funded health care system***

- Appearance plays an important role in social life. In so far as plastic surgery, both in its reconstructive and aesthetic parts, aims at restoring a socially acceptable appearance it belongs to the proper realm of medicine.
- The proper criterion for reimbursement of costs for aesthetic surgery is serious suffering, but surgery is not always the best way to overcome it. Sometimes psychological treatments are to be preferred. Even when surgery is required, trained clinical psychologists should be consulted to help determine how much surgery is desirable. Since the motives for wanting surgery are often obscure, even to the clients themselves,

private clinics should also seriously consider employing psychologists as part of an adequate informed consent procedure.

- Instalment of committees consisting of surgeons, but also of psychiatrists and psychologists, for advise in disputed cases to secure fair and equal access.

### ***Plastic and cosmetic surgery: hospitals and private clinics***

- Among European countries, considerable differences in training in plastic surgery exist with respect to duration of the programme, requirements for trainees, trainers and training centres, the selection of trainees and the assessment. If plastic surgeons migrate on a large scale, standardisation is required to prevent doctors from practicing without proper training. Co-operation between European organisations, such as the UEMS and EBROPAS, and national organisations should facilitate the harmonisation of the training in plastic surgery and the organisation of quality control, e.g. through accreditation and continuing medical education.
- An appropriate government department should register private cosmetic clinics.
- Private cosmetic clinics should publish annual reports. In this way reliable statistics about the total amount of plastic and cosmetic surgery can be acquired.
- Private cosmetic clinics should not be regulated solely by laws regarding the registration of individual medical practitioners and the protection of patients' rights, but also by laws concerning the quality of health care institutions. Adequate control of the quality of care that private clinics offer is only possible if they have to conform to the same conditions as other health care institutions. Systematic quality control should include, among others, the registration and control of data relevant for assessing the quality of services provided and the publication of a yearly public report.
- Most private clinics advertise in glossy magazines. To prevent misleading advertisements, governments should control it effectively.
- Associations and organisations of cosmetic surgery should formulate moral guidelines for their members (e.g. the Code of Ethics for the International Society of Aesthetic Plastic Surgery).
- Publication of adequate brochures about cosmetic surgery such as breast augmentation and implants. Written material however should be added to verbal information. Informing clients well is essential for cosmetic surgery; American, German and Dutch jurisdiction indicate that high demands will be made upon the informed consent procedure for cosmetic surgery.
- Co-operation of private clinics with respect to a register for breast implants nationally and on a European level. If private clinics do not co-operate with these registers, this may impede an adequate quality control of implants.

### ***Media***

- More long-term empirical research is needed to investigate the role the media play in the encouragement of eating disorders and (risky) cosmetic surgery.
- Broadcasters, movie-makers, advertising agencies, magazine publishers and the fashion-industry should be more critical of depicting extremely thin women.
- The media should be stimulated to play a positive role in matters concerning health and appearance. For example, broadcasters could co-operate with eating disorder associations to raise public awareness of eating disorders by showing this theme in soaps.
- One general restriction on advertising is recommended: a diversity of beauty ideals should be promoted.
- Promotion of media literacy programs in order to raise awareness of and prevent eating disorders. It may stimulate a critical evaluation of commercial images among girls and young women.

### ***Changing faces***

- Organisations that aim to empower and support individuals and to change the way society thinks about disfigurement should be encouraged. This could be done on the model of *Changing Faces*, a particularly successful organisation in the UK that supports people who have a disfigurement, whatever its cause – from birth, accident or disease. Support is offered through psycho-social interventions, which strengthens their self-esteem and self-confidence. These interventions provide a self-directed rehabilitation that complements and can sometimes be an alternative to surgical and medical treatments. Examples of the social skill training offered are face-to-face sessions, group activities, workshops and weekends. Present health care services tend to be structured around a medical model that treats the physical signs and symptoms and neglects the psycho-social effects. Changing Faces has adopted a different model; it has been evaluated extensively and has been found to be very effective.

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In 1992, James Partridge founded and is now the Director of Changing Faces, a UK charity supporting and representing people with disfigurements. His background is in health economics and medical demography. He is currently Chair of the NHS Equality Awards, a member of the Appraisal Committee of the National Institute of Clinical Excellence (NICE) and a Visiting Fellow at the Bristol University of the West of England (which recently bestowed him with an Honorary Doctorate in recognition of his research work, in partnership with Dr Nichola Rumsey). He is the author of *Changing Faces: the Challenge of Facial Disfigurement*, Penguin; 1990.

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Maria Teresa Ruiz is senior lecturer in public health at the Department of Public Health at the University of Alicante in Spain. Her research experience is in clinical epidemiology, inequalities in health by social class, gender issues and its relation to the construction of medical knowledge, and in the fairness of health care with respect to women.

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Nichola Rumsey developed an interest in the psychology of appearance and disfigurement whilst an undergraduate at the University of Exeter, and developed this interest in a PhD awarded in 1983. She is currently Reader in Psychology at the University of the West of England, Bristol and Research Director of the Centre for Appearance & Disfigurement Research (CADR). She is also the Programme Director for the MSc Health Psychology at UWE. She was co-author of *The Social Psychology of Facial Appearance*, co-editor of *Visible Difference: Coping with Disfigurement*, author of *Plastic & Cosmetic Surgery*, in: Baum et al. Cambridge History of Psychology, Health & Medicine; and *Visible Difference*, in: Comprehensive Clinical Psychology.

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Guido de Wert is senior lecturer at the Department of Health Care Ethics at the University of Limburg. He is a member of several committees of the Dutch Health Care Council and a member of the committee Medical Ethics at the Academic Hospital of Maastricht. He published and co-edited several books especially on genetics, artificial reproductive technologies and ethics.

**Henri Wijsbek**

Henri Wijsbek was a research fellow, together with Ineke Bolt, on the Beauty & the Doctor Project. He is presently working as a research fellow in the Department of Philosophy at the University of Amsterdam on a project called *New Reproductive Techniques: Who pays?*

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- Ward, C. *Informed consent in theory and practice: the new undergraduate curriculum*. *Br.J.Plast.Surg.* 53, 2001: 181-183.
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- Ward, C. *Why do patients sue? an analysis of 105 consecutive actions in alleged medical negligence relating to breast surgery*. *Journal of Clinical Risk* (In press)
- Ward, C. *Ethical basis of the surgeon/patient relationship*. Leading article in *Surgery* (In press)
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## **Annex I**

### **CONFERENCE ADDRESSES**

- Beaufort, de I. Ageing
- Beaufort, de I. Down is Beautiful
- Beaufort, de I. Offences to the Nose
- Bolt, I. Bumps, Bulges and Tummies. The Moral Meaning of the Obese Body
- Bolt, I. Ebony and Ivory: A Moral Assessment of the use of Skin Whiteners
- Bolt, I. Short Stature in Ethical Perspective
- Bridgman, A. Cosmetic Dentistry – When should the Dentist say no?
- Cole, J. Face and Self: On the Subjective Experience of Facial Difference
- Cole, J. Psychoanalysis, Surgery and Beauty
- Davis, K. A Dubious Equality: Men, Women and Cosmetic Surgery
- Davis, K. Surgical Passing: Or why Michael Jackson's Nose makes us queasy
- Erin, C. Duties to Self
- Hamilton, G.J.A. Health Care Financing Systems in Europe: a General Overview
- Hilhorst, M. Physical Beauty: only skin deep?
- Hilhorst, M. The Right to err Irreversible
- Hilhorst, M. The Value of Difference: Personal Identity between Sameness and Otherness
- Holm, S. Public Funding of Plastic Surgery: Can Limits be Set?
- Holm, S. Size matters – Penile Enlargement as a Test Case on the Ethics of Plastic Surgery
- Holm, S. The Aesthetics of Bodily Change
- Ingenhag, W. The Principle of Solidarity or the Split between Disease and Lifestyle
- La Parra, D. The Social Determinants of Obesity
- Laermans, R. Beauty is not only in the Eye of the Beholder: Towards a Social Approach of  
Beauty as Social Capital
- Laermans, R. Coping with Stigmatization: A Sociological Perspective
- Laermans, R. Health from a Postmodern Perspective
- Laermans, R. Plastic Surgery and Conceptions of the Self
- Maassen van den Brink, H. The Economics of Physical Attractiveness
- Martin, M. Ethical Questions and Deontological Decisions on Advertising and Appearance in  
Spanish Media
- Martin, M. Information, Action and Reaction: The Agenda Setting Process for Anorexia in  
Spain
- Parret, H. A Healthy Voice. Its Beauty and Quality
- Partridge, J. “.... and disfigurement matters too: the work of Changing Faces.”
- Ruiz Cantero, T. Rules and Regulations in Spain
- Ruiz Cantero, T. The Humanisation of Mastectomy

Ruiz Cantero, T. The Quest for Ideal Weight: Facts Associated with Self-perception of Body Image in Adolescents and Children

Rumsey, N. Aesthetic Surgery: Offering Biomedical Solutions to Psychosocial Problems?

Rumsey, N. Beauty and Genetics: Designer Babies or the Promotion of Diversity?

Simis, K. Adolescents Undergoing Plastic Surgery

Simis, K. Adolescents Undergoing Plastic Surgery; How Different are They?

Simis, K. The Adolescent and the Plastic Surgeon. The Moral Unease and the Facts about Appearance-related Surgery on Adolescents

Ward, C. Ethical Issues in the Breast Silicone Implant Controversy

Ward, C. Rationing and Resource Management

Wert, de G. Somatic Genetic Enhancement: The Case of Baldness

Wijsbek, H. Discourse on the Method

Wijsbek, H. Plastic Surgery and the Mental Suffering Criterion

Wijsbek, H. The Subjectivity of Suffering

Wijthoff, S.J.M. Regulations on Plastic Surgery in the Netherlands

## **ANNEX II**

### **Conferences Organised**

CHANGING APPEARANCES: RULES AND REGULATIONS

Amsterdam, 27-29 November 1998

MORAL CONSTRAINTS ON CHANGING APPEARANCES

Taormina, 10-12 September 1999

THE IMPORTANCE OF BEAUTY

Madrid, 27-29 April 2000

BEAUTY MATTERS

Venice, 24-25 November 2000

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